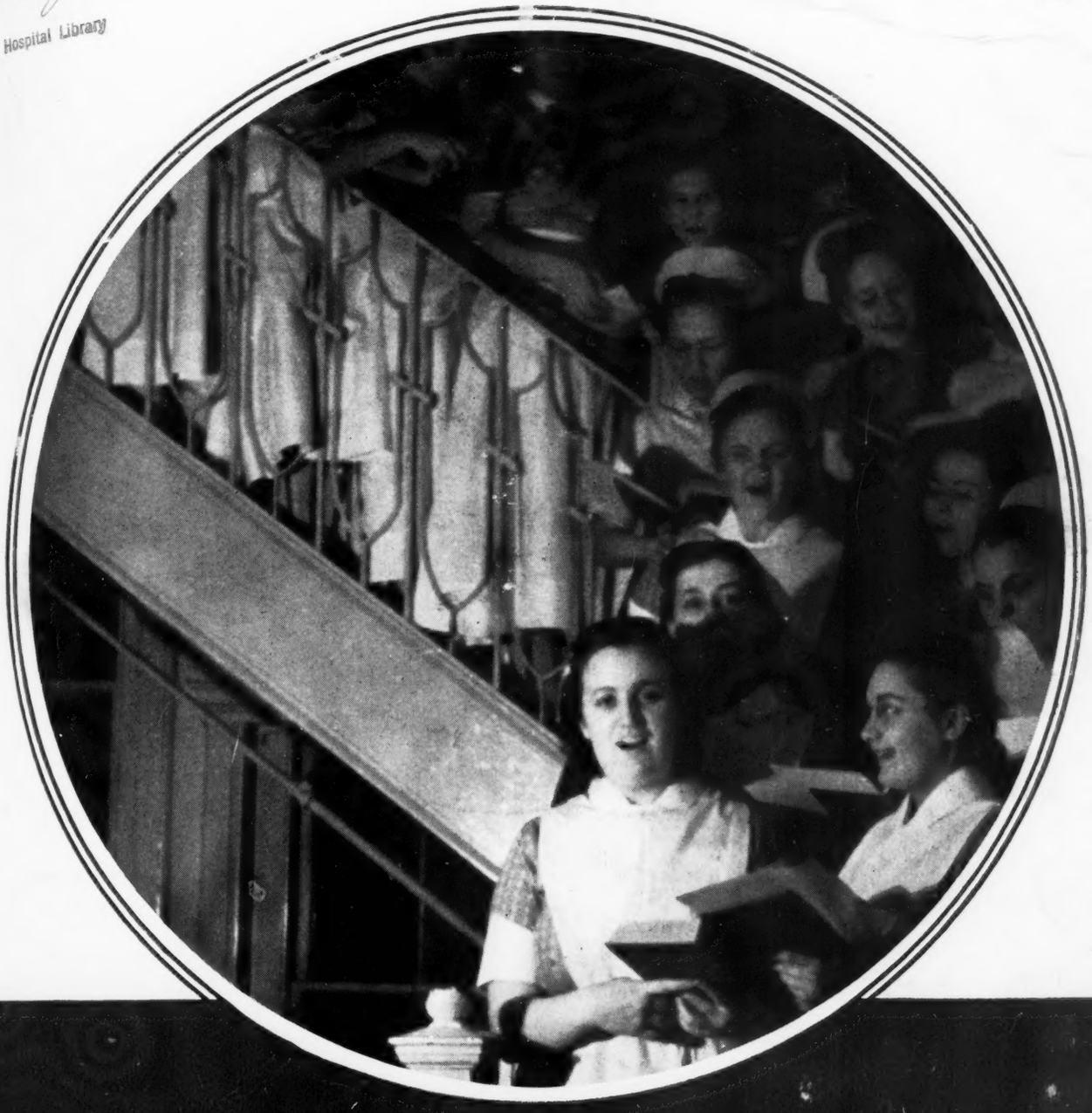

the MODERN HOSPITAL

VOLUME 65 DECEMBER 1945 NUMBER 6

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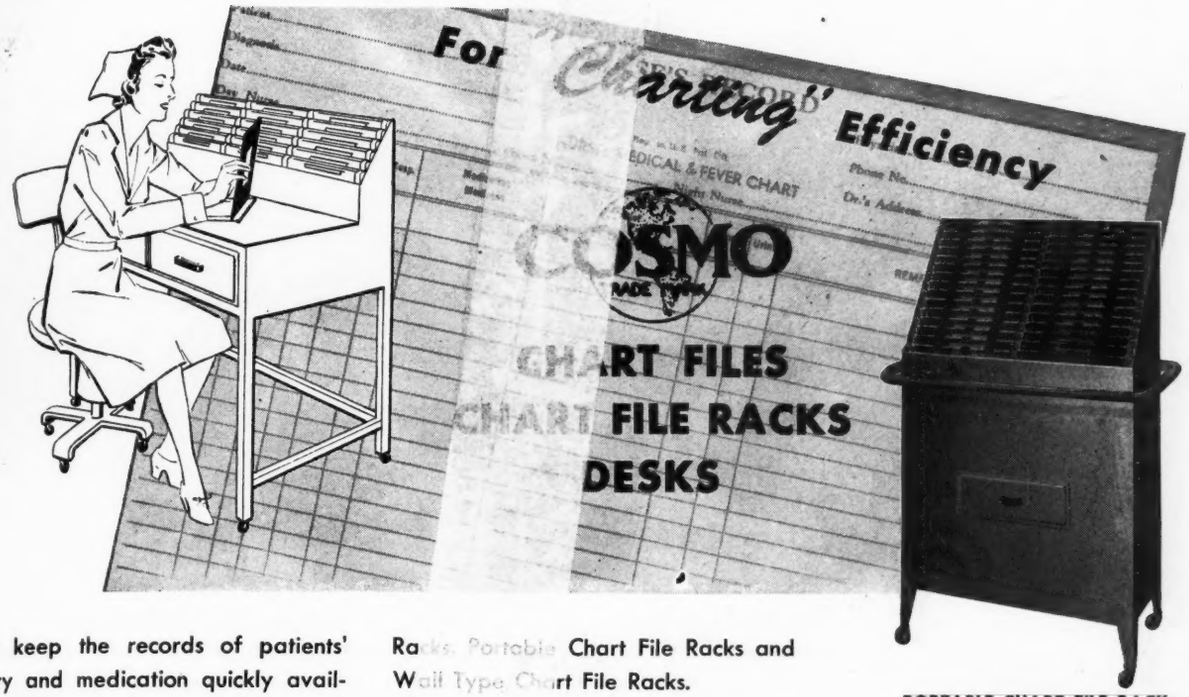

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If you are looking for suggestions

Regarding Your New Hospital

Here are one administrator's ideas with comments by four of his colleagues

RITZ E. HEERMAN

General Manager, California and Santa Monica Hospitals, Los Angeles

HOSPITAL administrators should now plan a long-range program of modernization in order that facilities in the vital public health institutions may better serve the public and, at the same time, take advantage of the scientific development that took place during the war in both civilian and military hospitals. This planning must also consider efficiency and labor so as to reduce the expense of hospitalization to the patient.

The suggestions offered apply to additions to and remodeling of existing facilities and to new hospital projects.

Hospital architects and consultants must consider the cost of operating the plant and arrange the departments in such a way that they can be staffed with the minimum personnel needed for twenty-four hour coverage.

Plant Facilities

The administrator should study present facilities or planned additions with a view to streamlining the service to the patient and the physician from the time the patient enters the hospital until his discharge. Some hospitals can save considerable administrative expense by having departments, such as admitting office, ambulance entrance, emergency rooms, cashier's office, telephone switchboard and out-patient departments, so arranged that during certain of the twenty-four hour periods the personnel of the various departments would overlap, thus saving professional personnel and assuring the patient of better correlated service.

Present and future facilities should also be analyzed from the standpoint of space for storerooms, central service and pharmacy. Too many hospitals have been planned without central storeroom facilities and storage space has been allotted merely as an adjunct to planning. This has created improper supervision, costly distribution and poor purchasing. There is little reason for not combining a great number of these services and placing them under one centralized control.

The actual service space devoted to care of patients should be analyzed from the standpoint of location of nursing stations and utility and treatment rooms, so as to lessen the amount of time and energy consumed by personnel in providing for the needs of the patient.

Laundry Facilities

Many hospital laundry plants should be modernized as some of the equipment is now inadequate and antiquated and, also, many of these departments have "grown like Topsy" by adding machine after machine in order to take care of new facilities which were planned by the management without considering laundry expansion. Without question automatic modern laundry equipment not only saves labor but increases the efficiency of the laundry from the standpoints of production and the increase in the life of the linens.

Takes Guesswork Out of Washing

The robot washer takes the guesswork out of washing and saves on supplies, as well as on water and steam, and this precision washing saves linens. We found at California Hospital, Los Angeles, that our inadequate laundry in an old building could be streamlined. We accomplished this not only by getting suggestions from a number of manufacturers but by taking the various plans proposed and having an architect draw them to scale in the area in use. The equipment was placed on these sketches by using pieces of cardboard cut to size. By this method, the superintendent, laundry manager and engineer could visualize the actual operation by following the linen through the laundry. We finally decided on our own plan, which was a combination of many experts' opinions. We also arranged to change the location of some of our present equipment in order to conform with this streamlining.

We established a production line from the linen chute to the linen sorting room. We designed portable sorting tables that could be rolled to the washer so that the washer could be loaded directly from the sorting table. From the robot washers the linen went to the extractors and was dumped from the extractors onto chutes leading to the mangle room. From the mangle room a belt placed the linen in the linen room. Similar streamlining was designed for the rough-dry and the press rooms.

The result of this modernization, which was effected without purchasing a great deal of new equipment, was greater efficiency with present labor and a 75 per cent increase in production. It is important to keep in mind that this was all done in our present space which had been termed inadequate by many experts.

Dietary Department

The dietary department of the hospital needs considerable planning and attention by the administrator and consultants inasmuch as no two persons can agree as to the method of streamlining and the type of distribution that is most efficient for a particular hospital. I have seen hospitals that were planned for central tray service switch over to bulk transportation of food to the diet kitchens. Any change of this kind shows inadequate planning. If the building is properly planned, no method of food transportation can compare with the central service system, provided such a system is streamlined and is under proper supervision.

The failure of these systems usually lies in the transportation of trays. Present dumb-waiters and continuous belt conveyors certainly need modernization. Proper engineering of these facilities could make them work more satisfactorily and carry the load needed.

Many of the present devices for keeping food hot or cold are inadequate. My objections to these systems are as follows: The electrically heated tray cart conveyors depend on separation of hot and cold items on the tray. This promotes inefficient and inadequate checking of trays. The heated conveyor for the hot foods is not the answer because the space could not be hot enough to keep a steak or soup at the proper temperature, as all of the items would soon take the temperature of the heated area. The cart system is also cumbersome, requires a great deal of manual labor and takes up valuable space.

Bulk transportation of food supplies certainly does not result in the most attractive finished tray because the appearance of food deteriorates rapidly with numerous handlings. It also promotes inefficiency in the service as 10 or 20 kitchens cannot be properly staffed with experts in checking the food service. No one can argue that handling, distribution and scraping of the dishes on the floor does not add to confusion and noise, besides increasing housekeeping expense.

My personal opinion is that the central tray distribution is the ideal plan and that the conservation of heat and cold on the individual items on the tray should be accomplished by a vacuum type of cover. The present single shell cover is inadequate. We also need modern engineering on dumb-waiters and conveyors so that they will have speed and capacity plus automatic features that will prevent breakage.

The dietary dishwashing facilities are inadequate because of poor planning by dishwashing manufacturers, as well as hospital architects, engineers and administrators. The hospital must produce clean, sterile dishes. To accomplish this we must have a well-organized dishwashing room with more modern methods of scraping and more than one dishwashing machine. The actual dishwashing machine should be separate from the final rinsing and sterilizing units but these units should work in series and the finished dish should come out on a conveyor system that would allow distribution to the various areas with a minimum of handling and without wiping. Glasses should be conveyed and stored in the original washing rack. In a properly designed dishwashing room the glassware need not be segregated for separate washing.

In the field of dishwashing we need a robot dishwasher, one that will maintain each separate tank at a predetermined temperature and at a predetermined pH with an automatic mixture of chemicals and an automatic dump when the tanks are dirty. Many dishwashing systems fail because they depend upon manual supervision.

Refrigeration in most hospital buildings must be modernized as the old refrigeration system is inadequate for the modern storage of food. Most institutions have inadequate space for frozen foods and there is no question but that frozen foods will play an important part in our dietetic service.

Engineering Department

The enginering department is one of the main centers of service for the patients in the institution and a department that needs adequate planning by the administrator, the architect and consultants. Hospital plants should be efficient, and by this efficiency should utilize the energy produced.

The hospital must have high-pressure as well as low-pressure steam; certainly there is no excuse for wasting the energy by reducing valves. In a medium-sized hospital plant high-pressure steam may easily be by-passed through an engine serving as a reducing valve, and the exhaust steam of this engine can be used for heating and the hot water supply, thus producing either electricity or exhaust steam as a by-product.

Every engineering plant should have its incinerator properly de-

signed so that the heat generated is conserved for water heating.

There should be a well laid-out department for maintenance and repairs, including machine, plumbing, carpenter and paint shops. The engineer should have charge of the maintenance and repairs on a scheduled system with preventive maintenance of every item of machinery and equipment in the plant.

Each maintenance mechanic should be furnished with a typewritten shop manual that specifically indicates the maintenance procedure he is to follow; he should be responsible for all the equipment listed in his manual. His work should be so scheduled that every piece of equipment will receive an inspection at planned intervals for lubrication and maintenance. When new equipment is installed maintenance data should be recorded in the master file and the work manual should be changed to include proper cleaning, lubricating and inspection of the new machinery.

Many hospital equipment manufacturers can gain valuable information by conferring with hospital engineers who can inform them of defects in the equipment from the standpoint of maintenance.

Water and Sewer Systems

The hospital engineer should be consulted by the administrator and architects so that water and sewer systems can be properly planned. Hot water systems should be of the circulating type, with segregation of the hot water serving the patient floors and the hot water system serving laundry and kitchen. The purpose of this segregation is to maintain the hot water service to the floors in a tank at a maximum temperature of 125° F. This would eliminate some of the hazards connected with hot water bottle burns, baths and showers.

Back-siphonage must be considered. The hospital should be designed so that there can be no contamination of the water supply. Many safety engineers do not feel that back-siphonage valves are the answer and are stressing the need for the elimination of any apparatus in connection with the toilet for flushing bedpans. This seems to me an erroneous idea; much nursing time will be wasted by the necessity for going back to a central utility room for flushing and cleaning bedpans. I believe that the answer lies in having all toilets on a separate water tank system with the back-siphonage on the tank supplying all the toilets and bedpan hoppers.

If this were done we should not have to worry about the individual toilet having back-siphonage control, and we should not have to eliminate the jet type of bedpan toilet or the hose flushing device at the side of the toilet.

Modernized Equipment

Manufacturers and hospital administrators should confer on the need for more scientific planning of hospital equipment. Some of these equipment items are as follows:

Cold and Hot Applications. The old screw-capped ice collars and ice bags are antiquated and should be supplanted by the modern freeze bag that has been tested for seven years and used in some of the Pacific Coast hospitals. A sealed rubber container, without metal parts, containing water and glycerin, is used. The liquid is sealed into the container by vulcanizing the intake hole. This liquid does not freeze solid and makes a flexible, comfortable, cold application which is more efficient than cracked ice. The container is cooled in a refrigerator with direct expansive coils in shelves so that the bag is maintained at 22° F.

When the nurse needs a cold application she removes from the refrigerator shelf a container of the proper size and shape and applies it to the patient. When the freeze bag is returned, it is dipped into a sterilizing solution and returned to a freezer shelf.

Considerable attention must be given also to the method of applying hot applications because it is one of the principal causes of hospital accidents. The public will not countenance hot water bottle burns and the court decisions in the past few years have proved this point. Under engineering I suggested that the source of hot water supplies on all floors should be on a separate hot water tank, maintaining a maximum temperature of 125° F. This would obviate one source of danger.

However, I feel that some manufacturer will develop a superior method of heat application, probably the reverse system of cold applications. In other words, a controlled heat cabinet could be designed to hold hot applications of various sizes ready for service when needed. One of the principal deterrents to the manufacture of such a cabinet at the present time is that constant heat deteriorates rubber. But this can probably be overcome by development of new flexible products which do not deteriorate under heat.

Nursery Bottles. The present method of hand cleaning nursery bottles with green soap is obsolete because such hand cleaning and rinsing can never remove all the soap residue. The cleaning of nursery bottles should be done with an automatic machine so that a high pH chemical could be used and the bottles could be thoroughly rinsed. Someone should design a nursery bottle washer and the manufacturers should be urged to standardize nursery bottles and nipples.

Breast Pumps. No maternity department should operate unless it is equipped with continuous suction breast pumps. There is no excuse in this modern age for any hospital's having the old type of piston pump that can contaminate the extracted milk.

Delivery Room Announcement System. The model delivery room should have a loud-speaker system to the waiting room. This has proved a time-saving element for the hospital personnel and it eliminates the hazard of relatives pressing for information at the delivery room and wandering in the corridors. The broadcasting system is quite simple

and provides for a foot-controlled microphone in the delivery room with a loud-speaker in the waiting room. At proper intervals the obstetrician presses the foot pedal and speaks into the microphone, announcing the birth and even letting the baby cry into the microphone. This has public appeal and is also a ready means of communication.

Nurse Call Systems. Nurse call systems should be modernized so as actually to record the call of the patient, the time the nurse answers and the time the nurse reaches the bedside. Such recording should not be on a master chart but on an individual chart for each patient so that it is part of the official nurse's notes. Her charting may be accomplished on the same recording.

Nursery Equipment. Many hospitals need to modernize their nurseries, providing cribs designed for individual care, ultraviolet radiation and better incubator equipment. Most incubators are hazardous and the manufacturers need to eliminate these hazards and place more safety features on the incubators before the hospitals can accept them as standard equipment.

Sterilization. Many manufacturers are now studying and bringing out new equipment for sterilization. The high-speed sterilizer for instruments should become an important factor in hospitals because of the time-saving element. Doubtless, many other items of equipment and supplies can be sterilized better at higher temperature in less time. Possibly, out of this experimenting many time-saving procedures will be devised.

For instance, the autoclaving of nursery bottles could be improved by designing standard nursery bottles and a standard container in which bottles could be placed in the autoclave. In this way the bottles could be packed in the container directly from the nursery bottle washer and placed in the autoclave and go directly in the same container to the milk formula room without human hands handling the individual bottles.

Hospital Beds. Manufacturers need to consider the modern trend in hospital bed construction. I believe that the new beds should contain such features as automatic push-button control for the elevation of the springs; automatic lowering or raising of the height of the bed; automatic lowering and raising of side rails, with each bed equipped with side rails that disappear underneath the bed when they are not needed. Arrangements should also be made for the standardization of hospital beds for proper fracture equipment. Why is it not possible automatically to elevate the patient for the bedpan?

Bedside Table. The large variety of bedside tables on the market is confusion itself. Certainly there should be some standardization of this equipment. Possibly the overbed table for meal service should be separated from the bedside table and this meal service table certainly should be a single pedestal type with either automatic or crank control in the hands of the patient. There is little excuse for a double pedestal table which cannot be used when traction or fracture frames are in correct position or when the patient is in other awkward positions.

In this article I have tried to stimulate thinking on the proper planning and equipping of hospitals. This subject is so vast that no single article can do more than touch on the various items. The problem, however, needs the joint planning of the hospitals, the hospital associations and the many manufacturers who have developed good hospital equipment and have shown an excellent spirit of cooperation.

I believe that further progress can be made if hospital administrators will give more thought to the subject. The administrator should be consulted because he has practical experience in hospital operations and knows the results that should be obtained in order to render the best service to the patient at the least expense. This expense must consider the man hours needed to operate the equipment and to render the service.

The administrator must also keep in mind the hazards involved. No piece of hospital equipment should be placed in service until a committee composed of the superintendent, the superintendent of nurses and the engineer has analyzed the equipment for possible hazards. The manufacturers could save considerable time, expense and sales resistance by considering many of these features before the product is manufactured.

REACTIONS

ALL readers will agree that hospital design should be governed more by function than by form. There are signs, too, that new hospitals may be built less like courthouses and more as efficient mechanisms for the care of the sick. The test is not whether they look pretty and smell nice, but rather their ease of maintenance and economy in operation.

I am still an agnostic on the subject of central tray food service. However, the author wisely forecasts the need for more refrigeration facilities for food storage. He would probably also agree that decentralized refrigerating units should replace the outmoded and more expensive centralized brine systems.

Gadgets appeal to me only if they are simple and make a necessary job easier. His comments on new types of ice collars and hot water bags and possible modernization of mechanical equipment merit attention, for he has had more experience in this field than the average hospital executive. I balk, however, at the proposed delivery room announcement system and would not permit the installation of such a device in a hospital under my direction.

The author has dealt well with plumbing hazards and needs, but there are other problems of modernization which are at least as important. For example, air sterilization and the use of aerosols, the routine use of chest x-rays and the trend toward routine gastrointestinal x-ray examinations in certain age groups will influence the design of hospital units in the future. It is hoped that research and studies by hospital administrators will help to solve these and other problems which have a bearing on the layout and the operation of hospitals.—**Basil C. MacLean, M.D., director, Strong Memorial Hospital, Rochester, N. Y.**

● ●

A NATIONALLY noted hospital authority once made the statement that as hospital conditions and treatment facilities change so rapidly, it might be wise to raze all hospitals every twenty-five years! Short of this method, there is no doubt that Mr. Heerman's article will be of inestimable value in the hospital field, es-

to the Author's Ideas

pecially to those who are planning new hospitals or modernization of old buildings.

Mr. Heerman undoubtedly has a vision of coming modernization in hospital buildings. His article indicates that he has put a great deal of intensive study on this problem, probably more than a great many of us have. His remarks regarding laundry facilities are very timely, as many hospitals today are faced with either an actual extension of their laundry or complete modernization. Neither has he spared the dietary department. His remarks deal mainly with food service to patients. Might we not also extend our vision to cafeterias for staffs and visitors?

Perhaps the near future will produce a modern iron lung in place of the cumbersome one which has given such satisfactory service. It has been my good fortune recently to see one of the latest models which is actually portable, the body being made of plastic. This, I understand, is going through extensive tests at the present time.

I am afraid that some of us, who may be criticized as being conservative, might not agree with him about the delivery room announcement system. For example, it would be a calamity if the foot pedal were to get stuck and relatives or friends heard even a part of the conversation that takes place in any delivery room, especially if things are going wrong. And what if this should come to pass and television were added to his suggestion!—**A. K. Haywood, M.D., director, Vancouver General Hospital, Vancouver, B. C.**

● ●

THE term "postwar planning" has given rise to a great deal of speculation concerning the wonders which are to be made available as a result of accelerated research during the war years.

Emphasis on planning has served to focus attention on the urgent need to review our hospital facilities in the light of the community's fast-changing requirements for hospital care. Not only must we give consideration to the excellence of our technical equipment and the development of a really functional building, but we must, if we are to succeed, reckon with the changing social and economic factors affecting medical and health care.

The community will look to the hospital to provide for aged Mrs. Jones, mentally ill Mr. Smith and the unfortunate Kelly child, seriously sick with scarlet fever complicated with acute appendicitis. Group medicine is a distinct possibility and consultation clinics on a private level appear to be a certainty. Blue Cross plans will continue to grow and have already created a great demand for two bed and moderately priced single room accommodations. The wards of the future will be four or six beds, with conveniently located utility rooms, making for greater flexibility. It is hoped that the outmoded nomenclature, private, semiprivate and ward, will be discarded in favor of more descriptive terms, such as single room and two bed room.

Nurse's call systems will be of the intercommunicating type; this will save personnel and make for greater patient satisfaction.

Surely some manufacturer will provide a protective device to keep beds and equipment from marring walls. None now on the market is completely effective.

Some architects are making traffic studies in hospitals, and well they might. Elevators should be so arranged that when Mrs. Webster goes to the operating room, which, incidentally, may be in the basement, she will not meet her neighbor on the way to visit a friend. Many steps can be saved, with consequent savings in personnel, if careful thought is given to the planning of nurses' stations and adjunct services.

Air conditioning of operating rooms, delivery rooms, labor rooms and nurseries will be standard in the modern hospital. Scientific lighting will be provided in the offices and kitchens, as well as in surgery.

Mr. Heerman's article includes many worth-while suggestions. However, his mention of the bed which can do everything but provide the sedative to put the patient to sleep leads me to say a word of caution. Undoubtedly many important new ideas will be developed, and the seemingly impossible of today will become the commonplace of tomorrow, but despite this, I would counsel against indiscriminate use of the novel gadget that is supposed to work miracles.

Never has cooperation in planning been so necessary. Architect, builder, administrator, equipment manufacturer, medical staff, board of directors and hospital staff, all must pool their thinking and ingenuity to solve the problem of providing adequate medical care at costs within the reach of all segments of our population.—**William J. Donnelly, administrator, Greenwich Hospital, Greenwich, Conn.**

● ●

ONE who spends much of his time visiting and inspecting hospitals of all types and sizes quickly comes to realize that the war years have cost us much in the quality of hospital service to the sick. Shortage in help, hasty instruction of incompetent and uninterested workers and lack of supervision have caused deterioration in spite of our best efforts to maintain the old standards.

Equipment and building materials have not been available for replacement or for well-planned expansion, and so it has been impossible to use our few workers to the best advantage. Such unavoidable deficiencies are not to be regarded as faults if we recognize them and strive constantly to correct them. Our goal must be to regain and even to excel those old-time standards.

Planning for construction is in the mind of every hospital executive. After we emerge from this inevitable period of dissension and turbulence there will come a time when both workers and equipment of suitable quality can be obtained. Those who are prepared with well-considered plans will be richly rewarded when that time comes.

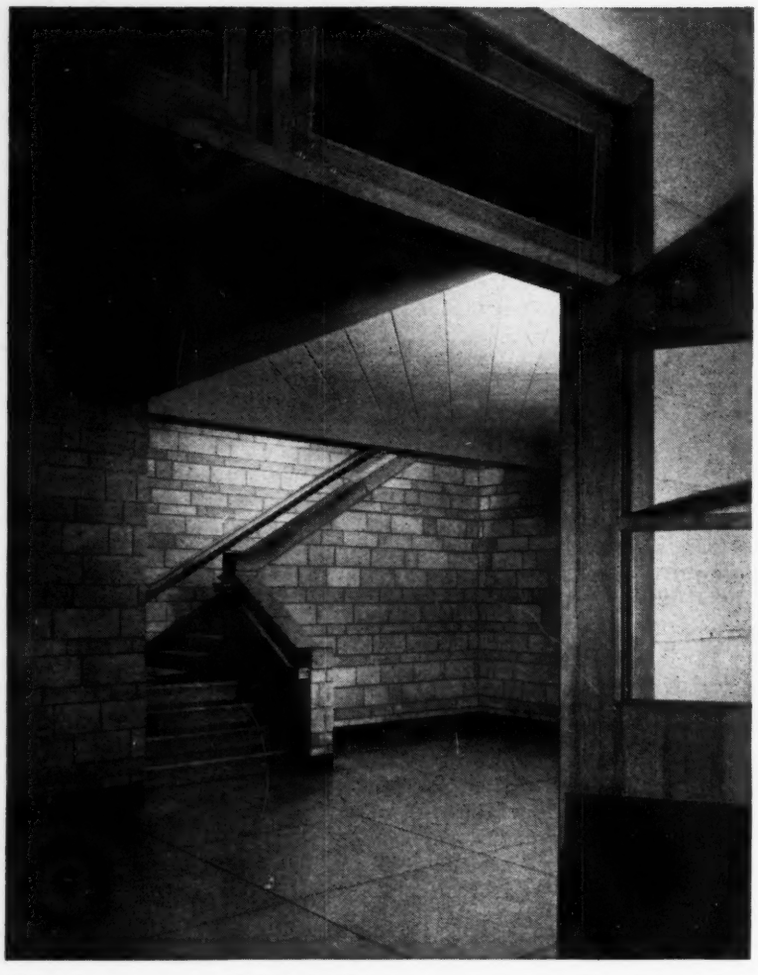
One of the best ways to sample public opinion is to make a dogmatic assertion and then study the protests of people who say it is not so. Mr. Heerman has not hesitated to employ this device. It will be interesting to note the reaction of administrators from large, medium and small hospitals to his conclusions. How many will agree with him?

The article shows evidence of intelligent study and long years of experience. One of its principal values lies in his stimulation of thought on controversial topics where there is little agreement. It points the way to future investigation and provides many valuable guide posts on the way back to satisfactory hospital standards.—**R/A Lucius W. Johnson, U. S. Navy Medical Corps.**

Concrete Masonry

COMBINES HIGH QUALITY WITH LOW COST

THOMAS H. CREIGHTON
Architect
Alfred Hopkins and Associates
New York City



Infinite variety can be obtained by various uses of concrete building units. In this lobby, several sizes of the units, laid out with staggered joints, and with the joints raked, produced a pleasing result at low cost since the "finish" of the walls is integral with the structural material.

THE pattern for design of hospital units for the small community has been pretty well established during the past few years by such publications as The MODERN HOSPITAL and such agencies as the Hospital Facilities Section of the U. S. Public Health Service.

We know now that a related system of medical centers, district hospitals and small local hospitals and health centers makes feasible, from both a medical and sociologic point of view, the comparatively small nursing and clinical unit that many of us had been afraid was impractical. We know also, as a result of surveys that have been made or are in process of being conducted by states, communities and private groups, that pressing needs exist for many such small local hospitals.

It would seem logical to assume, then, that a large volume of construction in this category might go ahead in the immediate future. Government restrictions that were born of the war have been lifted. Many plans have already been prepared or, at least, are in the stage of preliminary studies. Yet, at the moment, there is a very evident hesitation. The reason, I believe, is that the construction industry is in an extremely unsettled state, with the market obviously rising.

Preliminary estimates of cost that may be obtained right now will reflect this and may be frightening. Is it then necessary to put aside our plans and wait, perhaps indefinitely, before building these necessary facilities? Or should we reexamine our studies and see if perhaps we have been thinking in too extravagant terms?

We certainly do not want to resort to careless planning in order to save money. As a matter of fact, a plan well conceived from the point of view of doctor and administrator, functionally arranged, will probably be more economical than a poor plan. An examination of the schemes submitted in The MODERN HOSPITAL's recent architectural competition should satisfy the most skeptical that the plans most functionally perfect were also those resulting in the lowest cubage figures.

Equally undesirable is shoddy construction for purposes of economy. Every hospital administrator is keenly aware of the continual cost in materials, staff time, petty annoyance and patient discomfort of "savings" that were made in original construction at the expense of good construction. No, there would be little point in sacrificing good plans or good buildings in order to reduce the immediate building cost.

It is possible, however, that our first visualizations of the new small hospital, when everything seemed possible in the rosy "postwar" period, were extravagant in one way or another. Perhaps certain rooms were included in the plans which might be eliminated or combined. Perhaps the construction system was not conceived to take full advantage of the technics or the skills that are now available. Perhaps the materials that we intended to use were expensive, out of line with the economies that a small building of any character demands. A reexamination of these factors might result in a lower cubic-foot cost and a decreased total estimate of construction cost.

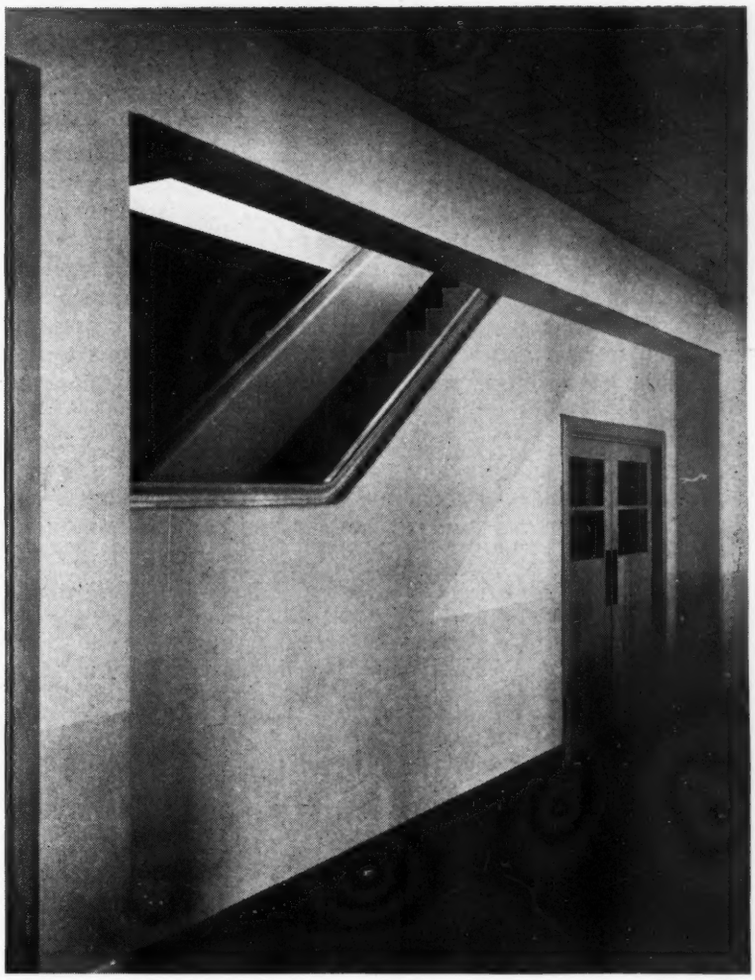
As an example of good materials that can produce economies, let's examine the improved concrete masonry units that are now available. It is perhaps unfair to introduce this construction material on the basis of low cost, because it has many other advantages, but the fact that it is inexpensive will undoubtedly be the reason for many architects' clients turning to it for the first time and discovering its other good qualities.

Concrete masonry units are simply concrete—a plastic, dense, strong and completely satisfactory construction material—poured in molds, hardened, cured and delivered to the construction site in sizes that are large enough to be economical and yet small enough to be erected as masonry units by individual masons. Concrete block, as we used to call it, got off to a bad start as a first-class construction material for several reasons.

In the first place, good architects and the potential owners of good buildings turned up their noses at it (before the war we were highly unimaginative in our acceptance of materials) and the result was that the mix, the texture, the color, the general appearance were developed for cheap, unimportant construction. Little imagination was displayed in its manufacture or in its erection.

Furthermore, it was recognized that the concrete units had to be sufficiently cured to make them satisfactory and this used to involve at least a month of exposure to the air after they were removed from the forms. Since few manufacturers had sufficient quantities of cured units on hand, their use in a building of any size would have resulted in undesirable delay. Now, however, there are available to block manufacturers machines that produce a steam-cured block within a comparatively few hours. The new concrete masonry unit can be controlled in its mix, pleasantly textured, attractively colored and ready when it is desired in almost any quantity.

Let's assume that you have become interested in concrete masonry units because of their low original cost in comparison to other masonry construction materials and that you have been further intrigued by the attractive appearance that the new units present. You will want to investigate the other qualities that



Above: Smooth-faced concrete blocks, with no finish other than paint, provide a pleasant, inexpensive wall in many spaces. Below: The concrete blocks of which Sheepshead Bay Hospital is constructed are so textured and colored that an interesting wall surface resulted.

any material used in hospital construction must have.

How about maintenance cost? A good concrete block, prepared by the modern machines, is as durable as a monolithic concrete wall. In other words, its maintenance expense is practically zero; worries about deterioration, upkeep, repairs can be forgotten. If you use it you will have a fireproof material. You will also have a material that is not an invitation to pests and vermin.

Because of its peculiar nature (the units are made with hollow cores in the center) you will have walls with good insulation value, thermally and acoustically. Coefficients of transmission of both heat and sound waves through the units are low in comparison to other masonry materials.

You will want to know about the possibility of applying finishes that seem desirable in hospital construction. In certain spaces the concrete masonry units can be left exposed. Smooth-surfaced blocks can be specified and, when they are painted, a wall comparable to a slightly textured plaster can be obtained. There is tremendous potential cost saving here in the elimination of costly plaster.

In other places, when a perfectly smooth finish is wanted, the blocks can be plastered directly, with no lath necessary. A much better bond is obtained between plaster and the masonry concrete units than between the plaster and the traditional sort of clay-tile wall furring unit. Of course, any further finish that may be desired, whether it is paint, paper, fabric or another material, can be applied over the plaster.

Alfred Hopkins and Associates became interested in the possibilities of this sympathetic material many years ago, before modern manufacturing machines made the present product obtainable. We realized that in high class work varieties of color, texture and methods of laying up the units were endless and were susceptible of an architectural treatment no other masonry material promised. Satisfactory results had been obtained before the war and further experiments during the war period, when many other materials were unobtainable, led to our use of the units in an important hospital project, the Sheepshead Bay Hospital for the U. S. Public Health Service. (See The Modern Hospital, March 1943.) Here a cavity type of wall was used, with concrete masonry units employed for both the outer and inner walls.

On the exterior, the blocks were specially colored and textured and laid in irregularly sized courses with staggered joints to add to the interest of the wall. Interior wall surfaces were, in most cases, merely painted, smooth-faced blocks giving a sufficiently sanitary surface, and a surface with less monotony than smooth plaster, for patients' quarters, offices and many other spaces. In "wet" rooms, of course, a different finish was used. The cost of this 400 bed hospital, even under war conditions and on a cost-plus construction contract, was about $2700 a bed.

On the basis of this experience and further research, the state of New York has approved the use of a similar construction method in two small hospital buildings that have been designed for the Wassaic State School. Since this is an institution for the mentally retarded, and many of the rooms are of a detention character, its plan is not typical of requirements for a normal small hospital. Yet, in the selection of materials and in the choice of construction methods, it involves every criterion that a small community hospital anywhere in the country would establish.

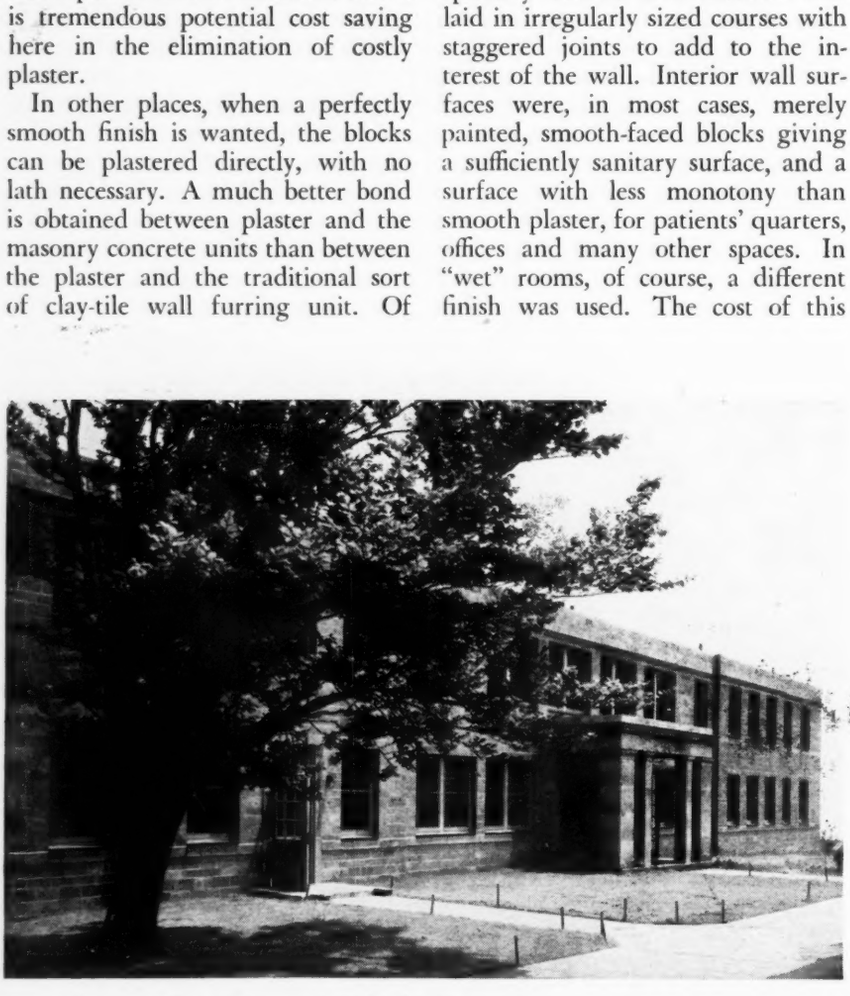
Low cost was a primary consideration. The estimated cost is 80 cents a cubic foot, or $3331 a bed, based on 1939 prices. Anyone familiar with hospital construction costs in the immediate prewar period realizes that the cubic foot cost of a small structure often ran as high as $1.

New York State has exceedingly high standards as regards durability and the lowering of maintenance costs in materials it approves. The masonry units specified meet these requirements ideally. Cleanliness and vermin-proofing are primary considerations, as they must be in any small hospital structure. Here again, the concrete masonry units are an ideal answer.

I do not contend that nothing other than concrete masonry units will: (1) answer the present pressing need for construction materials that are available; (2) use local labor forces; (3) have comparatively low original cost; (4) look well; (5) be sanitary, and (6) withstand the ravages of time, careless employes and thoughtless patients.

There are others, and The Modern Hospital has been doing a splendid job in bringing them to your attention from time to time. But here is one, which we are likely to overlook, that apparently combines in its qualities *all* of the desiderata.

At the present time, with needs as pressing as they are, with the building activity that we have been waiting for endangered by what appear to be high costs, we cannot afford to neglect any chance to reduce costs without sacrificing quality



A small hospital in Connecticut built during the war of concrete masonry.

Child patients may suffer

Psychic Trauma After Surgery

This study analyzes common fear reactions that occur in children and methods that can be used to prevent or minimize them

DAVID M. LEVY, M.D.
New York City

AFTER an operative procedure in children, fears, anxieties and other symptoms frequently occur. Commonly, they disappear in a week or so and are regarded as natural occurrences in view of the pain, the novelty of the experience and certain frightening aspects of the hospital and the surgical room. For a while, children may become cranky, petulant, more demanding of attention. Their sleep is disturbed by night terrors. When symptoms following an operation last for a month or more, they may be considered definitely as emotional sequelae, worthy of special study.

Although the duration of the emotional symptoms was used as a criterion for this study, it must be remembered that even in symptoms of brief duration we may have consequences that are quite significant. This may be true of the inoculations in the first year of life, an experience which, I hope, will at some time be thoroughly investigated. The majority of mothers whom I interviewed made little of the reactions of their children in this period. Unfortunately, special pains were not taken to gain material bearing on this point.

Fears Worst in 1 to 2 Year Olds

Special attention was paid to the earliest surgical procedures other than vaccinations and inoculations. Tonsillectomies and adenoidectomies comprised the large majority, 88 out of 124 cases. The largest percentage of emotional sequelae occurred when the age at the time of the first operation was from 12 to 23 months (58 per cent); next, at the age of from 24 to 35 months (33 per cent). Thereafter, there was a drop to around 8 to 12 per cent for all ages up to and beyond 12 years.

Several investigations were made to determine the accuracy of these data, for which the reader is referred to the original investigation.* Inasmuch as the children were referred for behavior problems, the question of the validity of our generalizations was considered. Because many of the children were referred for problems that are quite common in family life and because the larger number of those with emotional sequelae manifested no behavior problems before the operation, it was decided that our conclusions have general application. Considering all children 35 months and older, 50 per cent demonstrated anxiety symptoms lasting one month or longer.

The operation constituted a hazard much greater for 1 and 2 year olds than for older groups. The 1 and 2 year olds suffered more keenly because they respond more keenly to pain, are generally more dependent, have less experience in social contacts outside the home and have less understanding of what goes on. Their security in life is invested in a more limited area spatially and socially.

To the highest degree their world consists of just home and mother. The experience of the operation is more acute in every phase. They have less facility also with which to manage their anxieties. Night terrors are frequent in this period of life. The night terrors indicate that the anxiety is not successfully transformed into a dream; it breaks through as the scream dramatically indicates.

At this age the anxiety is not released in play. Unlike the 3 year olds, they do not have the words, the concepts and the skill required to play out the fearful event with toys. Moreover, it is difficult to explain to the 1 or 2 year olds what the operation is all about. To them, the operation is a raw and brutal experience, difficult to comprehend and difficult to transform and relate to other experiences. Their means of dispelling anxiety are limited to simple distracting play, restless behavior and closer contact with the mother. In turn, the mother is limited to simple reassurance, cooing and other demonstrations of closeness.

When we list the emotional symptoms following the operation, we observe first the contrast between those younger and those older than age 3 years. This difference consists of the fact that negativistic reactions, manifest as disobedience, temper tantrums, defiance and destructive behavior, occur in the older group alone.

Show Less Aggressive Action

One may conclude, in line with this investigation and with general clinical observations, that in response to the fearful event the younger children are more likely to respond with pure anxiety states, less complicated with aggressive reactions. The latter represent probably a revengeful attitude.

When the negativistic reactions are prominent, the symptoms of fear appear to play a secondary rôle. In some instances, the reactions appear to be exclusively aggressive, as though the feeling has little to do with fright but with an angry reaction against the forceful manipulation.

In one of our patients where there was ample opportunity to study the

*Levy, D. M.: Psychic Trauma of Operations in Children, and a Note on Combat Neurosis, Am. J. Diseases of Children **69:** 7-25, 1945.

problem in detail over a long period of time, the operation was a circumcision at the age of 6 years 7 months. It was preceded by a struggle of the boy with his father and the anesthetist. After the first few whiffs of ether, the boy jumped off the table, got out of the room and ran down the hallway, the father and anesthetist in pursuit. They finally overpowered him.

Immediately after the anesthetic wore off, he repeated many times: "They cut my penis, I wish I were dead." The rest of the day he never left his mother's side. The temper tantrums which he had manifested previously now developed into destructive rages. He developed a fear of closed rooms. He never had night terrors or fear of darkness, the two most frequent symptoms for all cases.

His fear took the form of a definite claustrophobia. When he was in the bathtub, the door had to be left open. If the mother ever closed it, he would jump out of the tub. The closed room evidently represented the surgical room in which the operation took place. The fear passed, but destructive behavior continued for years.

Generally, it would appear that at an early age, in keeping with the helplessness of the child, the reaction to danger takes largely the form of anxiety with little or no evidence of hostility. With increasing aggression, the reaction to danger is more likely to assume the form of hostility.

Not counting night terrors, the most frequent fear was of the dark, of doctors and nurses and of strange men. Fear of the dark represents apparently the fear of things that may happen in the dark, besides fear of separation from the protecting mother. When dependency on the mother is strong, the child fights separation from her, sometimes to a point of insomnia. There is also a feeling of defenselessness in the dark, because you cannot see. Frightening stories children hear about dangerous things that take place in the dark are another source of this fear.

The total fear reaction to the operation would theoretically be a fear of all strange places, strange people and hurtful objects. By close inquiry into all the details of the child's reaction, it is possible to delineate all the deviations from the total fear reaction.

The route from the general fear to the specific fear runs as follows: fear of all strange people; all people in white coats; doctors, dentists and nurses; finally, fear of a special doctor.

Every deviation is possible. The child may have, first, fear of a special doctor and then of all doctors or of all strange people. A child may start with a fear of all people in white coats and later on develop a fear of all strange people. It depends on the special circumstances of the events, which particular one had a more frightening aspect and the previous experience of the child.

Of the fears listed so far, fear of the dark remains longest. The others subside as the memory of the operation dims out. Fear of the dark is fed by anxiety from any source, whereas the other fears are more related to the specific experience. When fears are prolonged in time, the only one remaining may nevertheless be a specific fear relating to the operative procedure itself, especially of the needle or opening the mouth for an examination.

In some instances following an operation, there may be a general tenseness and anxiety that seem unrelated to anything specific. Later on, any frightening event may consolidate the diffuse anxiety into the typical postoperative fears.

When we add to our observations the study of children who remained free of any emotional difficulties following an operation, we may determine certain guiding principles that represent preventive measures, a prophylaxis of emotional distress resulting from an operation.

First, it is especially important to postpone an operation, if possible, to the age of 3 years or beyond. The rule of postponement whenever possible becomes especially important if the child manifests night terrors at the time, or other fears, or displays more than the usual dependency on the mother.

Second, it is important that the child feels the operation is necessary, that it is "explained." The explanation need not be detailed and accurate. It should be simple, brief and repeated as many times as necessary. The feeling that a thing is explained, even though the explanation is inaccurate, relieves tension.

Child Should Not Be Alone

Third, the child should go to the hospital with a familiar person, best with the person the child is closest to. The feeling of apprehension is reduced by that process alone. In the case of a young child, the mother should help him to bed. A sedative preceding the general anesthetic is advantageous. Whenever possible, the child should be spared the experience of seeing instruments, the operating room and of riding up and down in the elevator.

When he falls asleep in his bedroom, he should, if possible, wake up in the same room, with the mother there to greet him. This point is especially important. A child in a strange place for the first time in his life, and in acute distress, should at least have the security of his own protecting mother.

In principle, the operative procedure should be divested as far as possible of the strange, the frightening, the unfamiliar. No doubt in time the surgeon will regard the psychic response of his patient before, during and after the operation as intimate a part of the problem as the surgical technic itself.

The teeth are part of the patient, so Let's Not Overlook Dental Care

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THE subject of dentistry in tomorrow's hospital must be approached by considering not only the part that dental diagnosis and treatment should play in the care of the hospital patient but also the function of the hospital itself in health care for the community.

I regard dentistry as a health service and therefore just as much needed by the public as any branch of medical service. Many people (no one knows how many) who need hospital care will benefit in some degree by receiving dental care as a part of the service given them; many can get well only if given appropriate dental care. This situation is well recognized today and dental service of some sort is available in a large number of hospitals, usually limited however to patients admitted primarily for nondental ailments.

Others Need Hospitalization

On the other hand, many people (again we do not know just how many) who seek relief from some dental ailment are found to be in need of diagnostic and therapeutic services which can be provided more economically by the hospital. Recognition of this need is less general and arrangements to meet it are quite informal; planning of hospital service for such patients is obviously needed.

We may have to go much farther, however, in working out the relationship of the hospital and of dentistry in health programs for our communities, particularly if the hospital is to have a rôle in the preventive programs of the future. I approach this question with some trepidation, but with the thought in mind of what seems to be the more obvious relationships and needs.

The relation of dental foci of infection to numerous physical ailments is universally accepted. Hence, the inclusion of a dental service in the hospital to care for such conditions for both in-patients and out-patients is generally conceded. Also the occurrence of jaw fractures and other maxillo-facial conditions in hospitalized patients calls for dental cooperation in their management.

The question is: How far should the hospital go in providing dental service to its patients? What, if anything, is to be provided for those patients in whom it seems unlikely that there is a complicating dental disorder but who might be benefited as to their general condition by dental treatment?

First it must be said that there is too little factual information regarding the possible systemic effect on people, either sick or presumably well, of commonly occurring inflammations of the gums, periapical infections and other dental disorders. There is evidence that these conditions, particularly gingival inflammations and insanitary conditions commonly found in uncared-for mouths, may have serious side effects. The benefits of dental treatment applied to such conditions have been shown, for example, by reduction in the postoperative pneumonia rate in patients given dental prophylaxis preceding general operations.

How much farther the benefits of dental treatment of presumably nondental patients might extend is something yet to be determined. The first step in that investigation is the accumulation of data; the only reliable basis for that is the complete dental examination made by a dentist. X-ray examinations are usually required as a part of such examination and would have to be made in a large number of the cases. Naturally this would have to be followed up by appropriate treatment when dental disease was discovered to determine systemic results that might follow.

What Is Hospital's Function?

There is another point of view to be considered. If dental care is a general health measure and not just a treatment for a strictly localized disorder the question then is raised as to whether the hospital, with its function of ministering to the health needs of the community, should in some way see that dental care is made available for those needing it, even if they do not need other hospital service. Here we open up a large field since it is a well-known fact that dental disease is, next to the common cold, our most prevalent disorder. This uphappy situation is aggravated by the great tendency to new attacks and recurrence of dental disease from year to year.

Various agencies have undertaken to meet community dental needs in the past, virtually all of them approaching the problem as one of local disease only. Thus, we have dental clinics ranging from a one-chair unit set up in a church house

or other eleemosynary institution to more extensive clinics capable of treating hundreds of patients daily; most of these clinics not only are physically detached but have no definite affiliation with a hospital and no definite arrangement for obtaining medical consultation.

The situation is essentially the same with most health department dental clinics and clinics set up by boards of education. Such clinics usually have no close relationship to municipal hospitals or to other organized municipal health services. (In New York City dental service is included as one of four basic diagnostic and preventive services offered in the recently erected health centers, the others being chest, venereal disease and maternal and infant care.)

Perhaps in dentistry and dental service we shall find more readily than in other fields the meeting place of preventive and curative services as regards the individual patient. People can probably be trained more easily to seek a semiannual or at least an annual dental checkup than to seek a physical examination annually.

Opportunity for Health Education

The possibilities of making this the initial step in a general checkup, given the proper correlation of services, are obvious and should be given careful consideration. The opportunities for health education when the individual presents himself for dental examination need only be suggested. The antenatal clinics conducted by many hospitals, in direct connection with which dental service is given, provide an excellent example of the possibilities of such an arrangement.

Traditionally the hospital is a place for curative service while the health department has largely a preventive function. There are areas, however, in which these functions overlap and one of these is the field of dental disease. The antenatal clinics already mentioned, also well-baby clinics conducted by many hospitals, serve as examples of a blending of preventive and curative services.

There is more than a suggestion in what I have written that hospitals should assume the responsibility of organizing or participating in the organization of dental clinics as part of their general setup and that these dental clinics should provide service that not only will clear up existing focal infections but will make a contribution to continuing dental health as part of a general preventive service.

Whether dental clinics should be in the hospital or housed separately is a secondary point, in which the relative economy in overhead, and other factors as between a dental setup in the hospital and a separate although related dental clinic, is a determining factor. Another factor is the number of people who must seek clinic care instead of going to the private practitioner.

Organization of the dental service in, or in connection with, hospitals may be considered under two heads: (1) organization for the dental needs of the hospital itself, for both in-patient and out-patient departments; (2) organization of the dental services for community needs.

In large cities these two organizations would be separate, although with the relationships I have already suggested. Obviously, in such circumstances close physical integration would make housing arrangements cumbersome and would serve no useful purpose as regards economy of operation.

On the other hand, in small communities, hospitals are smaller, as are the dental clinics, and economy as to both personnel and facilities (x-ray facilities, for example) would best be served by inclusion of the dental clinic service in the hospital building.

Consider Both Types of Patients

Dental service in the hospital should be based on consideration of the needs of both in-patients and out-patients. The dental staff should be so organized that it will serve both departments according to their needs. In-patients' dental needs occur chiefly in the fields of diagnosis, surgery, treatment of acute oral infections and traumatisms. However, there is also a real benefit to be derived by many patients from less dramatic and acutely needed dental services, such as dental prophylaxis and temporary fillings in saveable teeth.

To cover such functions and, in addition, to perform the routine mouth examinations mentioned before, the staff should consist of (1) a chief who would be a qualified oral surgeon (not necessarily with the medical degree); (2) associate and attending oral surgeons and dentists; (3) one or more qualified periodontists; (4) dental residents; (5) dental interns, and (6) dental hygienists. The number on the staff will vary with the size of the hospital. The dental department should have one or more representatives on the medical board of the hospital.

A schedule of attendance should be set, first, to provide regular dental attention for the patients and, second, to provide supervision and instruction for the interns. A member of the dental staff and a dental intern should make ward rounds with the medical staff members; their attention should not be limited simply to cases with known dental complications obvious to even the medical intern, since dental considerations may enter into other cases.

Follow Up Cases in Clinics

Hospital patients often have dental disorders or disabilities that cannot be cleared up during their stay in the hospital; these should be referred to the out-patient dental clinic during convalescence and later, if necessary, to the associated dental clinic when attendance at the out-patient department is no longer needed. All essential dental needs should be attended to before the patient is fully discharged from hospital care and supervision.

As an example of needs felt by hospital patients but often not satisfied, let me cite the frequently occurring case in which clearing up of focal infections requires extraction of all teeth. The patient previously had enough serviceable teeth so that he could chew solid food. His ability to masticate such food is now reduced to zero and he is at the same time physically depleted by operation or illness. Full upper and lower dentures are essential to his physical rehabilitation and are needed for psychologic reasons as well. But hospitals today seldom provide dentures in such cases and there are few agencies in existence to fill this and similar needs for the average hospital case.

The out-patient dental department should provide not only the services specified as being needed by the in-patients but also, at the minimum, periodontic treatment where indi-

cated and common restorative services, such as permanent fillings and essential dentures, both partial and full.

An important member of the dental team is the dental intern. Like the medical intern he is useful in making examinations, taking histories, giving emergency treatment, assisting in oral operations and carrying out treatment programs ordered by his superiors. Like the medical intern he needs instruction and this should be provided on an organized and comprehensive scale so that he really learns something while in the hospital and at the same time becomes a more valuable member of the staff.

Rotate Intern Service

The dental intern should have a rotating service, spending part of his time in both in-patient and out-patient departments. Ideally he should also have a period of service in the associated dental clinic. He should spend some time in the pathology laboratory studying dental cases chiefly but not exclusively; he should have similar assignments in bacteriology and chemistry.

The intern should not be assigned exclusively to the out-patient department as is sometimes done; under such circumstances he spends most of his time filling teeth with no opportunity to learn what ailment the patient has and what its dental connection is. Such experience has its value but it belongs in the dental clinic rather than in the out-patient department, unless the two are combined.

The associated dental clinic needs little discussion here. It should be organized under the aegis of the hospital and some members of the hospital dental staff should be available on a regular schedule as consultants or as attending oral surgeons to whom certain operations will be referred.

The hospital dental interns should be assigned on rotation to the clinic; there, as in the hospital, they should have both supervision and instruction in the types of dental service to be provided. Rotation in the hospital of members of the clinic staff is also desirable. Hospital diagnostic facilities and consultation should be available to the clinic and treatment should be available for those patients found to need it.

It Simplifies Needle Threading

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Central Supply Room
Strong Memorial Hospital, Rochester, N. Y.

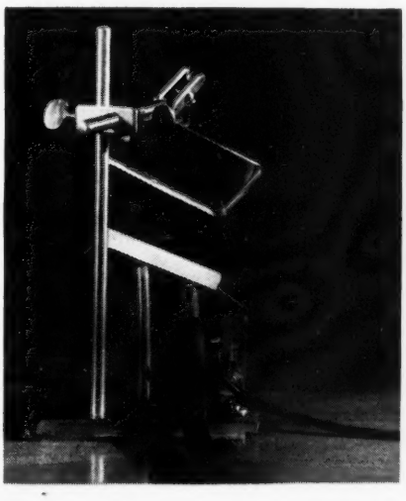
THE job of threading surgical needles by hand, especially those used for skin sutures, is tedious and time-consuming. At the Strong Memorial Hospital, Rochester, N. Y., some 200 skin needles are used daily. These needles have, in the past, been threaded by hand, mostly by volunteers whose output would average 60 needles an hour, but this pace could be maintained for only a short period of time.

Following some experimentation, a mechanical (suction) method* was developed:

A half-inch square metal bar 4 inches long was mounted horizontally on a movable metal post which was fastened to a sturdy base plate. The movable post allows this bar to be oriented in any convenient direction in space. From one edge, running along a central line on the top surface on the rod, is a groove of approximately the same depth as the diameter of the needles, and at a distance of three fourths the length of the needle along this groove was drilled a small hole (No. 76 drill). Just beyond this hole there is a stop against which the head of the needle rests.

On the under side of the bar, in line with the small hole, was soldered a nipple for a hose connection. This rubber hose leads to a trap the purpose of which is to retain any thread that may be aspirated into the hole. The bar was also bored through its axis into the space beneath the small suction hole.

*Patent Applied for.



A small 14 volt pilot light was installed in this cavity in a lucite adapter which was sealed to the metal rod to prevent air leaks at this point. The lamp is operated from a stepdown transformer and illuminates the tiny thread suction hole so that from above the needle and the thread are easily seen and approximated.

Mounted on Small Table

A suitable magnifying glass is also mounted on an adjustable bracket as a further aid in visualizing the eye of the needle and the position of the thread.

A hose from the thread trap is led to a vacuum pump. The pump and thread trap, as well as a bottle trap for oil fumes from the pump, are mounted on the lower shelf of a small metal table with casters and the needle threader is mounted on the table top, together with a bracket for a spool of thread and a measuring device and thread cutter which allows the thread to be cut in uniform lengths.

To use the device it is necessary merely to turn on the pump and light, place the needle in the groove with its head resting against the stop, with the eye of the needle turned so that the light is visible through it, and with the other hand place the thread close to the eye of the needle and the suction will pull the thread through the eye of the needle quickly and efficiently. The needle is then lifted and the thread pulled through by hand.

This device makes a monotonous job almost a pleasure, permits the threading of surgical needles at the rate of four times that of the old manual method and eliminates the eyestrain and fatigue that were the usual accompaniments of the task.

The Doctors Like Their Offices

Report on a successful experiment in hospital office rental

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ROZALIA A. REED
Director of Public Relations
Western Pennsylvania Hospital, Pittsburgh

"NOTHING but advantages" was the verdict of doctors and administrative officers of West Penn Hospital, Pittsburgh, when they were consulted concerning the use of hospital space for private offices by physicians and surgeons. When this use was contemplated more than a decade ago there were doubts of its feasibility from all points of view. Was it wise from the administrative standpoint? Would private patients want to come to a hospital to consult their physicians? Was the available space adequate for the needs of the physician in private practice?

As the first rooms were converted to their new service these doubts were quickly dissipated by the number of requests from staff doctors for office space. The first pavilion so allocated was soon filled and it was necessary to assign additional rooms in an adjoining pavilion until, at the present time, there are eight suites and eight single rooms in use.

Offices Out of Main Traffic

The choice of space was a wise one. In relation to the main part of the building it is apart from the main travel and the heaviest patient population and so provides the minimum of inconvenience for two similar but divergent responsibilities of the administration.

The office pavilions are close to a secondary entrance from a street which usually provides adequate parking space; they have the convenience of two elevators that also serve the laboratories wing. The electrocardiograph station is established in their midst. The advantages of the proximity of this station and the diagnostic x-ray, therapeutic x-ray, physical therapy and pathology, bacteriology and biochemistry departments are so obvious as not to need particular mention.

Conversion was made without a great deal of renovation. The first pavilion designated for offices was part of a new wing added to the hospital in 1927. It contains single rooms and suites of large rooms. All have bathrooms which are equipped with modern and efficient plumbing. The floors are covered with battleship linoleum. The rooms are equal in area, in installed equipment and in other appointments to any that are available in the city office buildings.

The rooms that had been singles for patients are now used, in most instances, as single offices, although a few have been combined to make office suites. In some cases the physicians using these also maintain offices elsewhere in the city and spend only part of their time in the hospital. In two instances several physicians share suites in the hospital for the convenience and practicability it affords in caring for their patients.

When only a single room is used by the doctor who does not have offices elsewhere it is equipped as an examining room. In a two room suite, which is the largest rental available, one room becomes the examining room and the other, an office for consultation.

Two large waiting rooms are available in connection with these medical offices, each located in relation to the elevator and stairs and at such distance from each other that a patient can reach his own physician with a minimum of effort. A hostess presides over these rooms and is stationed at a desk so placed between the two pavilions that she has full vision of the offices and can thus expedite the handling of appointment schedules.

This hostess is an employe of the hospital, but her services as a receptionist, and sometimes as an assistant with patients, are available to the physician who does not maintain a full-time secretary or nurse.

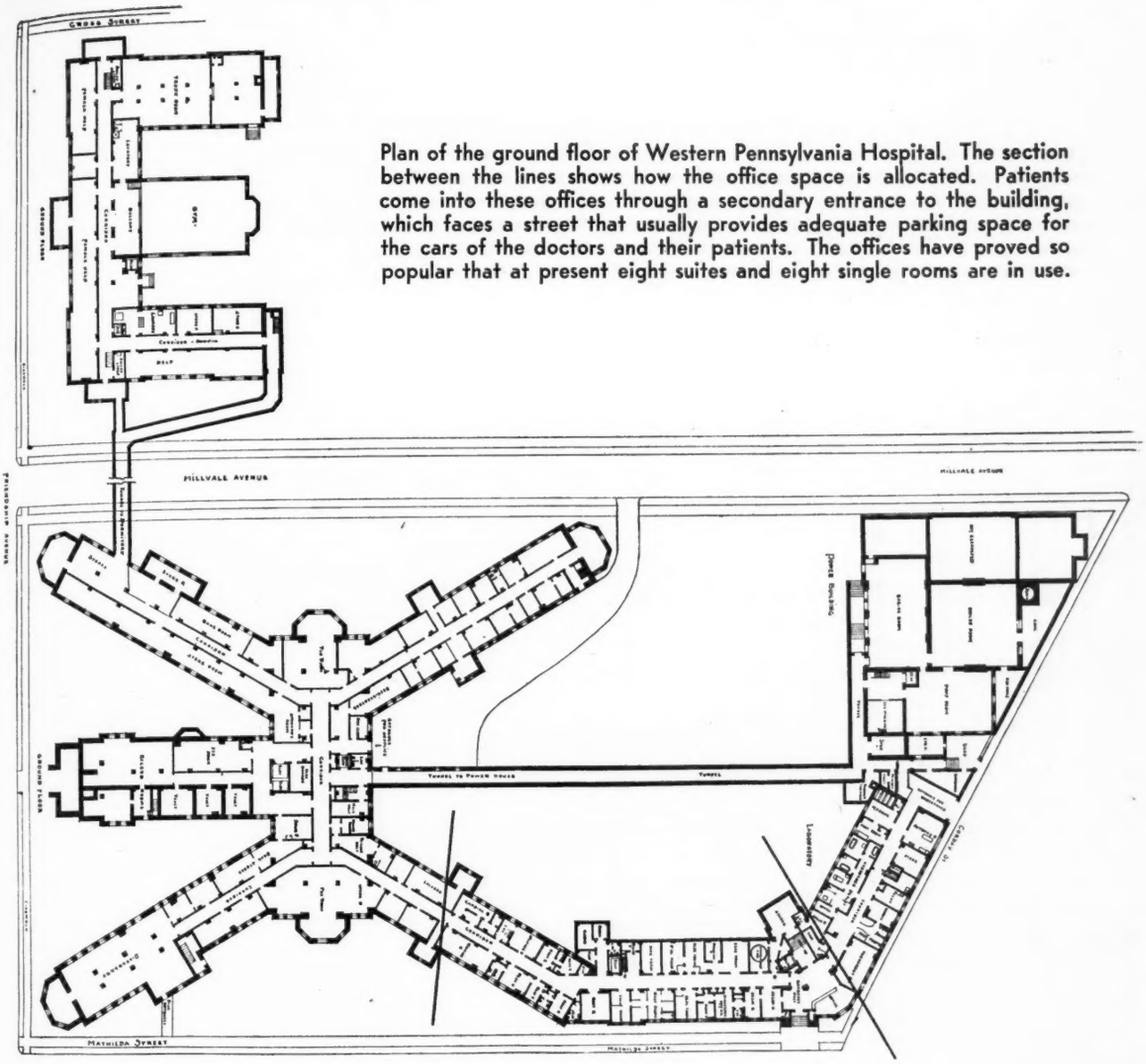
The use of this rented space is on the same basis as in office buildings: that is, it is in no sense available for hospital uses while under lease to a physician. For the most part rentals are carried by one man but he may if he wishes share the offices and examining rooms with others.

Rental Is Nominal

Rental for these offices, which is quite nominal, is based on floor space used and upkeep. The latter includes heat, light, housekeeping and maintenance of basic equipment. The physician provides his own furniture, both lay and medical, his own decorations and air conditioning units if he has them. Although he must have his own contract for telephone service, his calls go through the hospital's switchboard and his telephone is tied in with the inner-house system.

Although this group of physicians within the hospital does not constitute a clinic, properly speaking, it does tend to facilitate the clinic idea by making referrals and consultations easy within the diverse fields of medicine represented.

Time and energy saved by the physicians are incalculable, a saving that has proved most valuable in the past several years of shortages. Records on both in-patients and out-patients are kept within a relatively small



Plan of the ground floor of Western Pennsylvania Hospital. The section between the lines shows how the office space is allocated. Patients come into these offices through a secondary entrance to the building, which faces a street that usually provides adequate parking space for the cars of the doctors and their patients. The offices have proved so popular that at present eight suites and eight single rooms are in use.

area. Diagnostic information may be obtained directly from the radiologist and the pathologist, and there is an opportunity to judge at first hand, if desirable, the material and findings of these laboratories, and to consult with the laboratory man who, as is well known, is always in the van of medicine.

The plan saves the time and energy of the patient as well. Within a short period he can see his own physician and any other doctor whose experience and judgment are needed in the diagnosis and treatment of his disease. If pathologic laboratory study or x-ray diagnosis or treatments are required, they may be had or arranged for by the attending physician or surgeon, thus eliminating several trips to various parts of the city and tiresome new contacts.

The advantages from the hospital administration's point of view are both tangible and intangible. A visit by these private patients, at a time and under conditions not associated with overwhelming illness, tends to dispel the old, and frequently still present, antipathy to hospitals. They have an opportunity to see the hospital in a way that is uncolored by the detractions of a painful hospitalization or the grief attendant on the loss of someone dear to them. They can stand apart, so to speak, and view the plant and its operation with unblurred vision.

It is trite to remark that care of the patient is the first consideration of a hospital, but the remark must be made to point out that having doctors within quick call provides a form of security in the care of patients that cannot be wholly estimated. The hospital's responsibility for the patient must, in a sense, parallel that of the doctor and having the latter near by in cases of emergency is real insurance. Especially in accident cases does it prove valuable to be able to obtain prompt treatment for the injured person.

Since the rental is nominal, income from that source is negligible. On the material side, however, is the revenue from the increased work of the laboratories. This increase can in large part be recognized as resulting from the physician's ever-present consideration for the convenience of his patient. If the former were in a building elsewhere in the city he would naturally send the patient to the nearest pathological and x-ray laboratories, and that very easily might not be West Penn since it is not located near a large business district.

Comments on the Health Congress

This is the best plan yet advanced to meet a vital need, health leaders say, but is it a workable one?

IN THE October issue, The MODERN HOSPITAL published "National Health Congress," an article by Dr. A. S. Brunk, John R. Mannix and John F. Hunt. Briefly, the authors proposed the formation of a national body broadly representative of the health professions, industry, labor, agriculture and government, which would function to extend full health coverage to all the people of the United States through expansion of health facilities, a national prepayment system and better cooperation with government health agencies. That the article has stimulated interested groups throughout the country to lively discussion of the issues involved is evident from the many letters which have come to The MODERN HOSPITAL and to the authors. In these pages, we are presenting excerpts from some of the most interesting comments. It should be emphasized that the over-all reaction has been overwhelmingly favorable; nearly every one of the letters from which the following comments were taken expressed whole-hearted agreement on the need for action toward some voluntary health plan and endorsed the principle of the National Health Congress.—THE EDITORS.

FLORENCE KING
Administrator
Jewish Hospital, St. Louis

I AM wondering whether its activities would not duplicate those of existing organizations. Couldn't a joint committee of the American Medical Association, American Hospital Association and American Dental Association perform the same duties with more facility than could a large group enlisted from among the high potentates in Washington and the country at large?

Broad representation has its good features but so often results in disinterest and lack of concentration on the goal.

To my notion, the proposed National Health Congress savors of delusions of grandeur and it might, because of its broad and democratic membership, never get down to brass tacks and its ultimate mission.

M. B. BOCK
Advertising Manager
Wallace's Farmer and Iowa Homestead

OUR editors report that farmers are anxious for a satisfactory type of medical insurance and regret that the profession has not so far presented plans that seem to do the work. I can see that such an organization might be very useful in assisting farmers to better conditions in this field.

E. I. ERICKSON
Superintendent
Augustana Hospital, Chicago

HERETOFORE, all voluntary plans have been suggested by those most interested in maintaining and protecting the best parts of our voluntary health services. Their convictions and arguments against pending legislation have been accepted only at a substantial discount by the common man and his elected representatives.

To overcome this situation, it is imperative that some organized effort be made to bring representatives of all groups together for study and discussion of the problem and, if possible, to reach an agreement on a workable plan that will give promise of extending all health services to meet the reasonable needs of the greatest possible number of our citizens.

Assuming that such a plan can be adopted by the National Health Congress, it would no doubt receive a much wider acceptance in all quarters than has been true in the past. Furthermore, if a governmental plan is eventually adopted, recommendations to eliminate certain objectionable features would receive great consideration coming from a representative body, such as the proposed congress.

In my opinion, the proposal offers the only practical method of perfecting an acceptable health service for the majority of our population without incurring the dangers and deficiencies of socialized medicine.

JOHN F. McCORMACK
President
Hospital Association of New York State

CONGRATULATIONS to the authors! This is a splendid, timely exposition of an idea that should be put into concrete form just as quickly as the private health agencies are able to do it.

It is universally recognized that good health is an asset of great value to the individual and the community, that the means to possess it must be placed within the reach of all people and that this can be brought about either by the government through federal or state statutes or by the voluntary efforts of private health groups.

We, of course, favor the latter method. However, the important things to remember are that health protection for the public is going to be

demanded through one medium or the other, that it must include all types of service and that the machinery to provide it must be in existence at a fairly early date.

The Hospital Association of New York State is on record as favoring a comprehensive health program for the people of the state. In taking this stand we were fully aware that it would be necessary for health agencies other than hospitals to participate in the program if full coverage were to be provided for the population.

Accordingly, close alliances were sought with the Medical Society of the State of New York and the New York State Nurses' Association, and both of those organizations expressed approval of the idea with promises of full cooperation. While conditions and circumstances have not been conducive to rapid progress in the undertaking, nevertheless definite gains have been made, not the least of which has been the establishment of very friendly relations among the three organizations. All this gives promise of worth-while accomplishments in the not too distant future and at an accelerated pace.

New York is in accord with the idea of a National Health Congress representative of private health agencies; also the creation of similar assemblies on state and local levels. Furthermore, New York will support the formation of such bodies; indeed, it may justly feel that it has already taken substantial steps to bring them into being.

BASIL C. MacLEAN
Director
Strong Memorial Hospital
Rochester, N. Y.

THE success or failure of the proposed congress would depend, I believe, on whether the objectives, so well outlined by the authors, were sincerely and aggressively attempted or whether the organization became a bigger and better front to fight a rear guard action against the advance of a necessary social reform.

The most difficult problem in "extending a standard health protection to all people through voluntary means" is that of grading premiums according to ability to pay. If a solution can be found for this problem by a National Health Congress, the proposed plan deserves serious consideration.

CLEMENT W. HUNT
Director
Capital Hospital Service
Harrisburg, Pa.

IT IS inconceivable that the organizations whose representatives made up the congress would delegate the power to the congress which is implied in the objectives and measures stated. It just isn't our way of doing things. We have an example in our Hospital Service Plan Commission. Why aren't all plans offering the same national contract? Why is it that fewer than 50 plans are reciprocating in the extension of service benefits? If we cannot carry out such worthy purposes in an organization as small as ours, how could the proposed congress, representing numerous highly independent interests, accomplish its purposes?

HUGH CURTIS
Managing Editor
Successful Farming, Des Moines, Iowa

SOME voluntary group, such as the National Health Congress, is vitally essential; there should not be too much concern in the congress about government intervention. The field is so big that it seems to us the government effort might well be confined to the millions of financially disabled people who could in no way be considered as prospects for a system of voluntary health payments. Such a setup is operative now in many departments, among them the Farm Security Administration.

The majority of farmers — and especially the financially secure farmers of the Midwest and the East — are individual customers and would regard a total plan for health under government supervision with quizzical eyes. I think the reason there has been some tolerance of the idea of a government health trust is that physical facilities overall in the farm areas are distressingly lacking. Your congress could and would handle that.

As we see it, the congress, operating on existing surveys, needs first to provide adequate health facilities in every major farm trading center. Such facilities would of themselves be an attraction to young doctors and doctors who are relocating now that the war is over. Beyond that, the congress should have a tremendously effective personnel bureau — call it "placement service" — directed to the end that farm trading centers have fairly adequate medical staffs.

I have in mind here a college community of 5000 people set smack down in the midst of a very good farm territory peopled by many thousands more potential patients. This town has one doctor at the present time. It is a good town, a rich one and it needs help. Here's where the congress could function.

The history of such voluntary health associations and groups has been that they were known best to the enthusiasts promoting them and they never had adequate advertising and promotion to those who were to be subscribers under them. This is to say that your National Health Congress should be promoted to both farm and urban people with the same amount of unanimity and donated space as has been given to some of our war loan drives, stamp sales, safety campaigns and recognitions of returning veterans.

I can't stress too strongly the need for a sales force and a promotion department. And let's, for heaven's sake, not do this sales job in the usual desiccated and antiseptic style employed by most public-good campaigns. I think the best type of copy is the testimonial type in which we repeatedly sledgehammer home the fact that the people are using the service. Personal experience — among farmers at least — pulls far more strongly than does textbook advice.

F. K. HELSBY
Director
Blue Cross Hospital Service
Kansas City, Mo.

I OBJECT to the size of an organization which would have representatives from the nine fields mentioned. However, in reviewing these I fail to find any that could rightfully be eliminated. Yet the unwieldiness of such a body might make it difficult to accomplish the necessary objectives quickly.

WILLIAM P. BUTLER
Manager
San Jose Hospital, San Jose, Calif.

I LIKE the positive stand that you have taken. This is exactly what is needed. Much misinformation has been spread regarding the need for medical care. Twelve years ago I began making the statement in this locality that anyone in the county who needed medical and hospital care would have it, and that guarantee still holds. The fantastic thousands who needed it in this community didn't materialize, and I wish that every community would "call" the critics, because I know that a similar situation would exist in most communities. The cost of medical care is advancing and will continue to advance, and it is my belief that adequate voluntary health insurance is the only correct answer.

SAMUEL BRADBURY, M.D.
Germantown, Pa.

I THINK the project is excellent, but I am sure that it will be of little use unless it puts the patient first. It seems to me that its discussions will get into the same wrangling and stalling that characterize so many of the efforts made by organized medicine. I'm not sure, too, that the time has not passed and it is too late for any voluntary organization to accomplish anything of moment.

JOHN H. HAYES
President-Elect
American Hospital Association

YOU couldn't get the group really to agree on anything of real value. This congress would have no power except to make suggestions—too many of them now! You mention: "Empowering a national health administration under its control to carry out its directives." How? And isn't that national control again? I remain one of those who believe in states' rights, which means states' control. I still feel that anything new and better in medical care in Illinois or any other state will be copied by all other progressive states; that competition in improving the care of the sick makes for better care for all; that attempting to standardize it is like attempting to standardize mother love.

We have had health congresses for years in the many gatherings of doctors, hospitals, nurses and others which have helped to make sick care in this country the best in the world. It can be much better, no doubt, but backward states will not move any faster under your plan than they have in the past, I am afraid. In addition, I feel that we have too many organizations now, all trying to tell doctors and hospitals what to do.

M. POLLAK, M.D.
Medical Director and Superintendent
Peoria Municipal Tuberculosis Sanitarium, Peoria, Ill.

WE BADLY need a forum where all those concerned and affected by a health program can work out a plan for the improvement and economical purchase of health services. Such a forum should provide an opportunity for constructive work without anyone's being called a "Bolshevik" who might propose a new idea.

On the other hand, I wonder how the proponents of the congress can organize "a legislative body with the power to act." This would be just as objectionable as passage of the Wagner-Murray-Dingell Bill. After all, every state and every community faces a somewhat different problem, which cannot be handled uniformly the country over by legislative fiat. I also wonder why the proponents have left out of their proposed membership representatives of such national organizations in the health field as the American Public Health Association and the National Tuberculosis Association.

F. STANLEY HOWE
Director
Orange Memorial Hospital, Orange, N. J.

HERE is a gleam of an idea which somehow we have got to get into action—and soon. However, it is difficult for me to visualize getting anywhere in a short time with a National Health Congress made up of one or more representatives of 48 hospital, medical, dental and other associations.

While I am not by instinct an autocrat, I am convinced that real progress toward a sound solution of this problem will not be made without a pretty highly concentrated authority and responsibility. My idea would be that a small commission, including representatives of the various fields indicated in the membership of the congress, could hammer out a program calculated to get at the fundamentals of the question in the interest of society generally without having to wade through the maze of conflicting legal and professional interests certain to be involved.

I am also concerned about any nationwide plan which is certain to be inequitable compared with a plan based on the initiative of individual states. The service plans have a similar concern, and I think quite justly, believing that statewide Blue Cross plans will be much better adjusted to the needs of their areas than would any scheme that was nationwide, with the inevitable tendency to set up uniform benefits.

N. E. HANSHUS
Manager
Luther Hospital, Eau Claire, Wis.

I MAY be a bit impatient, but my reaction is that the National Health Congress as outlined is unnecessary. It is a duplication of what established organizations should be and, I believe, are trying to do. The three national hospital associations, the American Medical Association and the nurses' associations are quite aware of what is taking place with reference to compulsory health insurance. Other organizations, such as labor, agriculture and the chamber of commerce, are studying all bills being proposed with reference to health measures. I just don't see where the National Health Congress would fit into the picture.

GUY J. CLARK
Executive Secretary
Cleveland Hospital Council

THE article is timely and I hope it will result in some action. The challenge is not too big if the health professions wish to retain some self-determination. It would seem to me that the ultimate aim would be the National Health Congress, but the foundation must be built through cooperation in local medical societies and hospital groups up through state medical societies and state hospital associations. If sufficient interest could be enlisted on a statewide basis, I think you would be more likely to establish a sound foundation than if you start to formulate national committees without a better understanding of the project by those at the grass roots.

WORTH L. HOWARD
Administrator
City Hospital, Akron, Ohio

THEORETICALLY, the idea appears to me to be very practical and sound. However, it could fall into the hands of a group that is disorganized and unruly to control, and I am particularly fearful that the small cog called the director may develop into a dictator.

S. A. RUSKJER
Administrator
Waverly Hills Tuberculosis Sanatorium
Waverly Hills, Ky.

THE plan has the same weakness revealed in all similar plans for health insurance on a national scale and on a voluntary basis: in the absence of compulsion, a certain percentage of our population will not willingly enter any plan. Could it be made ever so attractive in coverage and ever so economical to the individual subscriber, there will still be a large group that is too thoughtless and careless or indolent to provide insurance for itself and its families as long as the voluntary element is present.

If voluntary health protection could be backed up by a certain measure of compulsion, brought to bear on the local community rather than on the individual, it could provide complete coverage for all such communities. The success of any plan, in my opinion, depends on its being made applicable to 100 per cent of the population. Anything short of this will still leave active agitation in the field for a government-controlled plan.

ROBERT H. REED
Editor
Country Gentleman

I AM impressed with the simple good sense the article makes. I agree that agriculture has a great deal at stake in national health. I feel that through editorial treatment of this vitally important subject we can further the proposals you make.

D. A. ENDRES
Superintendent
The Youngstown Hospital Association
Youngstown, Ohio

KNOWING the number of divergent views in the hospital field alone, I wonder how the views of the various organizations represented in this congress could ever be crystallized into joint action. It seems to me that this is organizing from the top down instead of from the bottom up. In

order for such a congress to fulfill its purpose a great deal of missionary work would have to be done to obtain public support. I am very much interested in prepaid health plans, but I am pretty thoroughly convinced that these things have to be developed and made to work at home.

LEE S. LANPHER
Superintendent
Lutheran Hospital, Cleveland

THE proposal loads the congress with professional people. I think it is the professional group's responsibility properly to supervise and set up the health care program. A question arises as to whether these groups can so divorce themselves from their own economic interests as to develop a good, practical voluntary health program. Complete coverage will cost the American people many millions, yet no provision is made as to how such a large financial operation can be handled. It may be that the authors have not given sufficient representation to the citizens, who are the recipients of health care and who must pay for it.

O. A. HANKE
Editorial Director
Watt Publishing Co., Mount Morris, Ill.

THE people will be served. If they aren't served through private enterprise the government will serve them. Much of this social legislation is forcing us in private enterprise to do some things which we should have done long ago. We are for the congress.

PATSY KLEIN
Associate Editor, California Cultivator

WE HAVE never favored a federal or state compulsory health plan. A patient's faith in his doctor is, after all, a strong factor in medical practice and to say arbitrarily who shall treat whom would destroy, or at least weaken, this principle. There is no doubt that better medical facilities are needed, especially in rural communities. A congress such as you suggest would seem to be the most logical way to raise general health standards and at the same time keep away from socialized medicine.

HOWARD S. PFIRMAN
Secretary
Connecticut Hospital Association

NO METHOD of solving the problem of better health has been suggested other than governmental control or its antithesis, Blue Cross. The former takes the pattern of bureaucracy, while the latter, although democratic, is too slow to benefit the greatest number now. Certainly, there is no time like the present to act.

NELLIE GORGAS
Director
St. Barnabas Hospital, Minneapolis

I THINK it is grand that we have someone who does some creative thinking and is willing to take the initiative in developing some kind of constructive plan for the future. I am not sure how well the congress might work out, but it should be seriously considered. It is a prodigious task, but what other alternative is there?

LUCIUS W. JOHNSON, U.S.N., M.C.
San Diego, Calif.

HUNDREDS of thousands of men and women who had never known about adequate dental, medical and hospital care have learned a lot while in the armed service. When they return to civilian life they are going to demand that such care be made available wherever they may be. It is going to be a demand that cannot be ignored or hushed.

At present we are not prepared to satisfy the demand. Nearly everybody realizes this. Standards in our country are far above those in any other, but still they are below what the public is going to demand. It is difficult to see how a countrywide organization for adequate care can be maintained except by government funds, and that means government control.

Public health plans under government control in other countries have developed some glaring faults. Our fear of seeing the same faults develop in the United States has induced some of our most powerful professional organizations to oppose all movements toward medical, dental and hospital service under the control of the government. Many are now coming to believe that instead of opposing it leaders of these professional groups should climb into the driver's seat and guide the movement into safe and sane channels.

The proposed congress promises to be a long step toward the goals of adequate service for the public and adequate protection for the professions. Its aims should be to filter out and clarify the views of all interested groups, to find the common ground on which all can stand while boosting better public health.

The congress must provide opportunity for all to have a fair hearing. There must also be a constituted authority that can make decisions and eliminate impractical suggestions. Besides the organizations mentioned in the article, the opportunity to be represented must be extended to all state boards of health, also to the American Public Health Association. And what about the osteopaths, chiropractors, naturopaths, Christian Scientists and other groups from which there will be loud protestations if they are not represented?

A. C. JENSEN
Superintendent, Fairmont Hospital
San Leandro, Calif.

THE congress is a long step in the right direction. However, unless prompt, enthusiastic support can be enlisted from all parties concerned, and especially the medical profession, I am afraid it will be too late to turn back the stampede toward government control. Support must be gained from industry, agriculture and, especially, organized labor, which has made evident its feeling that the only way workers can get adequate care is from the government. An aggressive campaign might do the trick.

L. DONALD LAU
Executive Director
Associated Hospital Service of Arizona

I BELIEVE that any action taken with the attitude of forestalling government control of the health professions is doomed to failure, though I believe that government control is impractical. Our attitude is important: if we are honestly concerned with the welfare of the people as a whole and have no selfish motives, government control will never become a reality.

FRANCIS C. HOUGHTON
Secretary
Hospital Association of Rhode Island

IT SEEMS that the plan is feasible. It is bound to require a lot of hard work but certainly would be well worth the effort.

A. L. HOWARTH
President
Washington State Hospital Association

IT OFFERS the best chance we have left to conserve voluntary health service, hospital and medical care.

VERNE A. PANGBORN
University Hospitals, Iowa City, Ia.

ONE of the greatest handicaps we have endured in the hospital field is the lack of any program other than Blue Cross to combat government legislation. We must have a program around which all health workers can rally if we are to meet this challenge. An organization along the lines of the proposed congress is a necessity.

LEROY COX
President
Hospital Association of Rhode Island

CAN the individuals who should be named members of the controlling committee give the time necessary to initiate such a program? I do not believe so.

AULTMAN ADDS 120 BEDS

OUTLINE OF CONSTRUCTION DETAILS

GENERAL DATA: New 120 bed addition to present hospital, increasing the total to 300 beds and providing a new main kitchen, cafeteria dining room, hospitality shop, four operating rooms, central supply and sterilizing rooms, pharmacy, laboratories, autopsy and conference rooms. Serving a city of 125,000 population and outlying territory of 90,000.

CONSTRUCTION: Brick and Indiana limestone exterior, fireproof throughout. Floor, concrete joists and tile. Interior partitions, terra cotta tile and brick. All windows, reversible sash. Stairways and railings, steel and wrought iron. Roof laid on 1 inch insulation.

HEATING: Two-pipe vacuum low-pressure steam with moderator control. High-pressure steam for sterilizers. Recessed radiators. Operating and autopsy rooms air conditioned with automatic individual temperature and humidity controls.

LIGHTING: Indirect in all patients' rooms; fluorescent in laboratories.

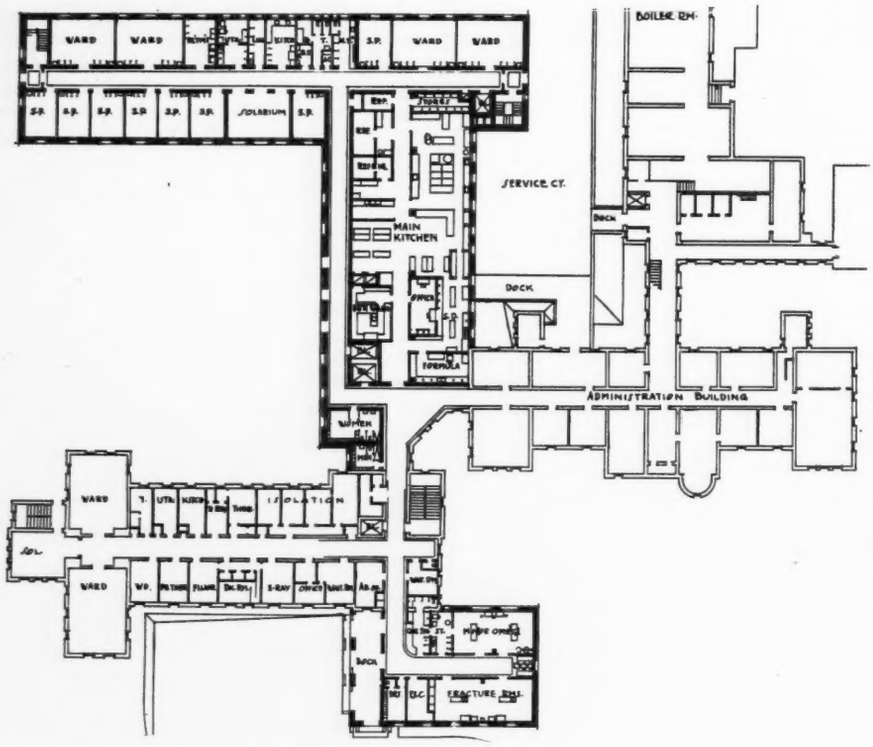
WALLS: All utility, scrub-up, substerilizing, treatment rooms and floor kitchens, ceramic matt glazed tile wainscots. Main kitchen, salt-glazed tile. Patients' rooms, plaster.

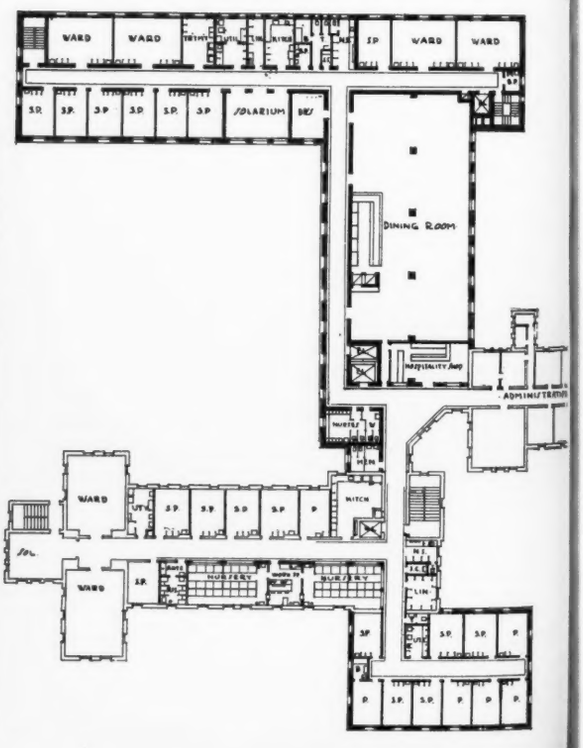
FLOORING: All corridors, solariums, utility, floor kitchens, laboratories, pharmacy, autopsy and toilets, terrazzo floors and base. Operating rooms, "nonstatic" linoleum. Patients' rooms above first floor, dining room and hospitality shop, battleship linoleum. Main kitchen, quarry tile. Patients' rooms on first floor, asphalt tile.

CEILINGS: All corridors, solariums, nurses' stations, utility rooms, floor kitchens, main kitchen and dining room, acoustical tile.

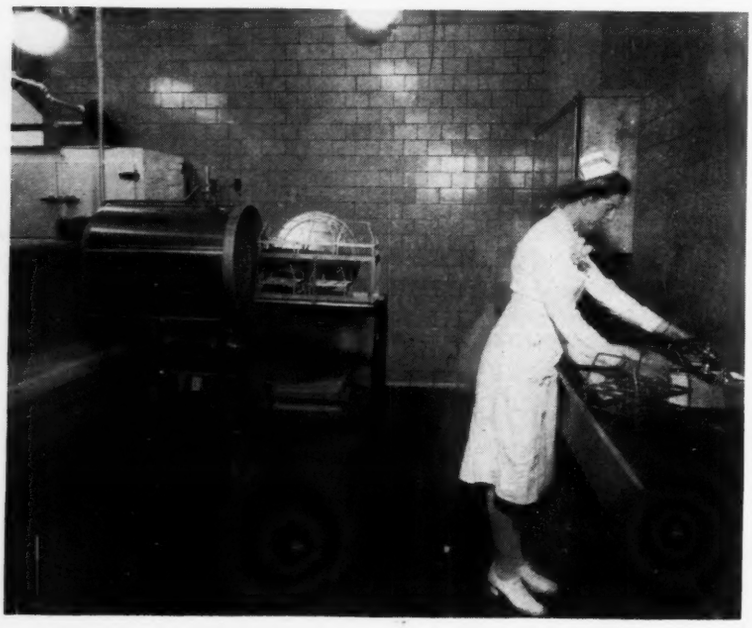
CALL SYSTEM: Lamp annunciator; audible paging system.

REFRIGERATION: Separate units, walk-in refrigerators with individual temperature controls in main kitchen.





Above: Plan of the first floor showing kitchen area and service court, patients' rooms and x-ray department. Below: The formula room adjoins the dietetic office. Right: Second floor plan showing relationship of old and new structures and the passage connecting the nurses' home with the hospital.



JAMES STEPHAN

Administrator
Aultman Hospital
Canton, Ohio

ELEVATORS: Three, self leveling, automatic selective, collective controls; speed 100 feet per minute. Three dumb-waiters with automatic selective controls.

KITCHEN: Forced ventilation with temperature-controlled air.

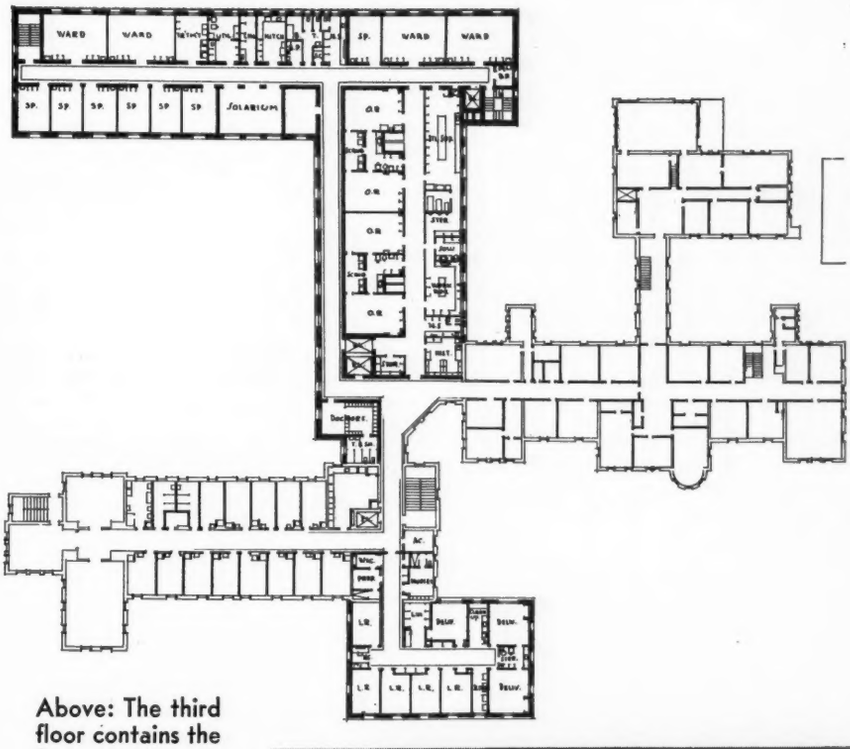
OPERATING ROOMS: Individual automatic temperature and humidity control for each room from central air-conditioning plant on roof. Walls and ceilings, flat-tone, deep eye-rest green. Floors, black conductive linoleum. Dark metal cabinets.

LABORATORIES AND PHARMACY: Metal cabinets, linoleum counter shelves, soap stone sinks, work counters and chemistry table. Exhaust fan located on roof for entire chemistry laboratory.

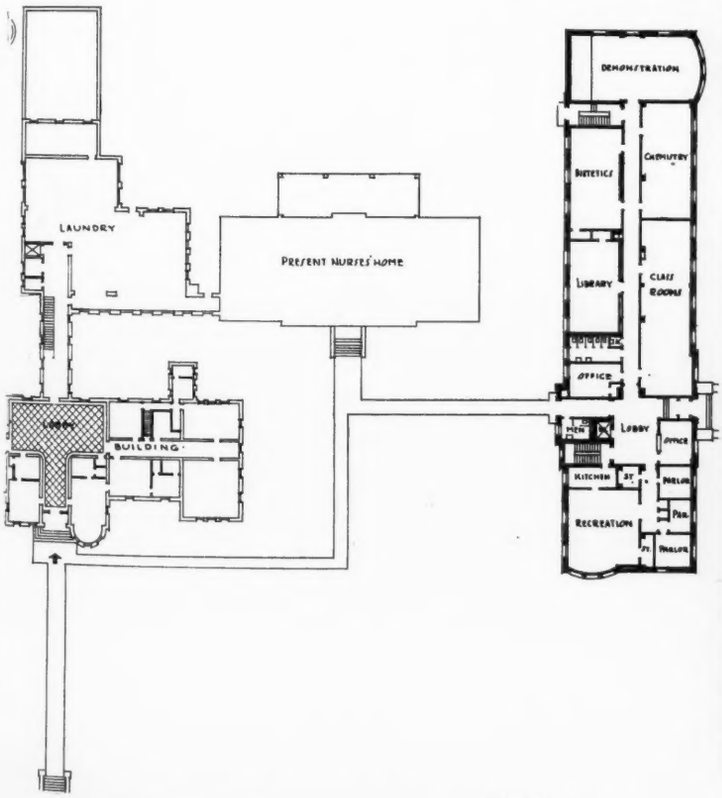
CENTRAL SUPPLY: Metal cabinets and tables with linoleum tops. Soap stone sinks and drain boards.

STERILIZERS: Pressure washer and high speed sterilizer in operating rooms. All utility rooms have 16 by 24 inch utensil pressure sterilizer, reflux stills for all distilled water.

COSTS: Building, $560,000; equipment, $94,600. Volume, $631,500 cubic feet. Cost per cubic foot, 88¾ cents for the building, 15 cents for equipment. Cost per bed, $4675 for the building, $790 for equipment. Plumbing, heating, air conditioning and ventilating, $96,000 (15 cents per cubic foot); electric wiring, $33,000 (5¼ cents per cubic foot); elevators and dumb-waiters, $37,000 (5¾ cents per cubic foot).



Above: The third floor contains the four new operating rooms and sterilizing units. On the fourth floor (not shown) are the laboratories. Right, above: A typical four bed ward. Right, below: The hospitality shop is located on the second floor.



Politics Has No Place *in this county hospital*

ROBERT R. STEWART
Superintendent
Maumee Valley Hospital, Toledo, Ohio

UNTIL May 15, 1943, Lucas County General Hospital, Toledo, Ohio, was operated as a unit of the Lucas County Home and Hospitals, comprised of the General Hospital, the William Roche Tuberculosis Hospital and the County Home and Annex. This unit was governed by the board of county commissioners, which in turn appointed a general superintendent from the ranks of the political party in power.

This maladministration and a lack of proper accounting records were a continual source of bickering between the city and county officials as to whose responsibility the patients were and the average per diem cost of each.

Appointed Bipartisan Board

In 1939 the Ohio legislature enacted additional county hospital statutes which permitted the appointment of a bipartisan board of trustees of four members and also permitted the financing of public hospital service on a basis other than poor laws. In April 1943 the board of county commissioners appointed a bipartisan board of trustees composed of two outstanding business men and two doctors for terms of four, three, two and one year, so that every year after the first a trustee would be appointed to a four year term. These men have done an outstanding job and contributed freely of their time and experience.

The commission then surveyed the hospital property and deeded it to the board of trustees. The board of trustees appointed a superintendent who had had previous experience in hospital administration.

The standard hospital accounting system was installed, there being put into practice for the first time a uniform classification of accounts and internal controls.

The hospital began making its own purchases, this function being removed from the general county purchasing department which was not familiar with the specific needs of the hospital.

The method of establishing public responsibility for patient care was reversed from the medical discharge stage to the admitting stage. The city and county relief directors were required to establish and maintain currently correct files of persons eligible for either in-patient or out-patient care.

Only emergency cases are admitted if there is no active card in the file. Determination of responsibility in these emergency cases is made within seventy-two hours. Township cases are admitted upon presentation of a signed order by the proper township official.

Arbitration procedures were established to determine responsibility for disputed cases. First, the city and county relief directors meet with the superintendent. Any cases that cannot be agreed upon are submitted to a representative of the state welfare department whose decision is final. Since June 1943, only five cases have had to be adjudicated this way, thus a cause of much dispute in the past is relieved by a routine procedure.

After a series of rate negotiations, a uniform contract was drawn up and signed by city, township and county officials. This contract calls for billing rates for the ensuing year at the preceding year's actual per capita per diem cost. At the end of the year, if the per capita cost is over or under the billing charge, a subsequent billing or refund is made in either case. In all cases payments must be received monthly, fifteen days after receipt of invoices.

Realizing that capital equipment would eventually wear out, we were able to get a $25,000 appropriation for replacement of equipment, this equipment to be amortized and charged into per capita cost.

Owing to economic conditions, the number of persons eligible for medical relief reached an all-time low during the war, thus reducing our occupancy to about 40 per cent of capacity. At the same time voluntary hospitals were overflowing and accepting only emergency cases. The medical staff and board of trustees decided to open the beds to persons who were unable to obtain accommodations in voluntary hospitals. This arrangement will not be continued after the end of the emergency, as this is primarily an institution for the indigent of the community.

Removed Stigma of Charity

In order to attempt to remove the stigma of charity, it was decided to change the name of the hospital. Suggestions were asked from the medical staff, the nurses' alumnae, the Academy of Medicine and other civic organizations. Maumee Valley seemed to be the predominating choice and on Nov. 1, 1944, the name was officially changed to Maumee Valley Hospital.

Many other improvements have been made and the hospital is now self-supporting whereas in previous years it was running an annual deficit of between $150,000 and $200,000.

The most amicable relations exist between the administrator and the various political subdivisions that do business with us. Employes are now assured of their jobs regardless of party affiliation, which creates a better sense of security and consequently a job done better. This is how one hospital proved that politics does not belong in the administration of a city or county hospital.

A Plan for Improving
HOSPITAL TREATMENT of PSYCHIATRIC PATIENTS

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This essay won the second prize of $350 in the contest sponsored by The MODERN HOSPITAL *on improving the care of psychiatric patients*

MAN is in the unique position of having gained such considerable control over his physical environment that the task of maintaining existence need no longer demand an overwhelming portion of his energies. The new frontier in human progress has ceased to be an economic one but is found instead in the area of human relationships. We are and must become increasingly sensitive to our social environment.

Our desperate need is dramatized by the appearance of the atomic bomb; it represents the extreme control which science has gained over the material world but so poor is the quality of our human relationships that this apex of control finds its first expression in destruction of our fellowmen.

A slow-growing concern about human values is discernible in our handling of labor-management problems, in our attack on racial prejudice and even, perversely, in the organization of the Army. This trend is illustrated by the increasing extent to which psychiatrists are being called in to solve these problems.

However, while psychiatrists are busy adjusting human relationships in industry or in the Army, those obtaining in the psychiatric hospital are allowed to grow haphazardly, too often on the basis of fear and misunderstanding. Many mental disease hospitals exercise a system of authoritarian control over employes which would never be tolerated in any really modern industrial or business organization.

Such poor knowledge of human motivation is displayed that only the dregs of the labor market are attracted to most of the unskilled jobs in the hospital. (It is all too easy to blame this situation entirely on poor working conditions but these working conditions in themselves are symptomatic of a general lack of consideration for the human needs of the individual employe on the part of the administration.)

It is time for a reevaluation to be made of the psychiatric hospital's social organization in terms of the human values which are so important for the world today. These values are being promoted by psychiatry in many areas of our social life and it is time that they were brought to focus on psychiatry's "home front," the mental disease hospital. With this need in mind, the following plan is submitted for the improvement of hospital treatment of psychiatric patients.

HOSPITAL TONE AS A FACTOR

William Alanson White writes that "a hospital is like a miniature society. It develops its cultural ideals in the same way and it is exceedingly important that these cultural ideals . . . should help to build up enduring traditions which have as their objective the welfare of the patient."[1]

These cultural ideals and the tone or morale that they create have perhaps more influence upon the patient than does any other aspect of the hospital.[2] Through the all-pervading medium of hospital tone, the patient makes his first important contact with the hospital and by it he evaluates his new surroundings, determin-

[1]Forty Years of Psychiatry, New York and Washington, Nervous and Mental Disease Publishing Co., 1933, p. 123.

ing whether he has found the security he needs and whether his burden of anxieties will be lightened so that he may cautiously find his way back to reality.

The same tone sets the patient's attitudes toward the hospital and thereby determines his acceptance of the therapeutic technics available. Obviously, hospital tone plays a tremendously important part in determining whether the patient will be able to rebuild a healthy personality and return to the outer community.

Along with direct influence upon the patient, hospital spirit plays an important part in supporting the other functions of a mental disease hospital. A high state of morale provides inspiration for research, for teaching and for the initiation of mental hygiene activities in the outer community. It is hard to imagine these activities being carried out effectively without the support of an alert hospital body united in mutual commitment to high ideals.

The purpose of this paper is to demand that intelligent attention be directed to the factors that create hospital tone. I shall attempt to outline these factors and then develop a program by which control can be exerted over them. Planning to control these factors is one vital way by which the hospital treatment of psychiatric patients can be improved. Such planning will be as necessary after other desirable reforms have been effected as it is now.

Factors Determining Hospital Tone

Hospital tone is made up of the ideals and attitudes that govern the actions of employes within the institution. This excludes the ideals and attitudes held by patients but it is felt that the predominant tone is set by employes by virtue of their control over most hospital situations. At any rate, it seems wise to consider only those ideals and attitudes held by employes.

Hospital Ideals and Purposes: A hospital in which it is felt that the primary purpose is to keep potential disturbers of society under custody is likely to have a very different atmosphere from one in which the primary purpose is to restore individuals to mental health. The purposes of an institution are incorporated into a whole body of ideals and it is important that these ideals originate from the best psychiatric source and that they be clearly defined.

Personal Adjustment of Employes: Ideals in themselves are of potential value only. They must be expressed in action to realize their worth. It is necessary, then, that hospital employes be of such a caliber that they are able to accept the ideals and express them in all their activities with the patients. This ability demands good personality adjustment.

An attendant on one ward where I worked was a former patient who was still troubled by such insecurity that he seized every opportunity for asserting his dominance over the sick people in his care. In almost every problem of adjustment within the ward, he would approach a solution with violence or the threat of violence. This is an extreme example but it is equally true that minor maladjustments have their harmful repercussions on the patients.

Good adjustment in attendants is important to prevent them from working off aggression on patients. It is also important because attendants are the most obvious representatives of the outside world for the patients. They thus readily become the models for imitation and it is important that they be good models!

Group Integration Among Employes: Just as important as the integration of the individual is the integration of the group for the creation of good hospital tone. Wherever men work together, the quality of relationships that they maintain among themselves is an important factor in reaching the end for which they have been brought together.

In discussing this problem, I shall be concerned with the social needs of employes, realizing that all men crave the respect of their fellows and inevitably seek social recognition in their job. I shall also be concerned with social structure, recognizing the different specialties that are practiced within the hospital and emphasizing their complementary nature, avoiding a sense of caste.

Place of Attendant in Hospital Organization: Inasmuch as the attendants are the employes with whom the patient is in most frequent contact, they are the readiest communicants of ideals and can be proportionately effective in helping patients.[3] In fact, we would be justified in considering the attendant as the nucleus of hospital organization[4] and this concept will run through our discussion of a practical program.

Our attention throughout this paper will focus upon the attendant, upon his ideals and attitudes and upon his relationships with the rest of the staff. Though we must focus somewhere, this may be an overemphasis. Yet I feel justified in making it because the attendant has been neglected so much in the past that attention directed toward him should light up areas of hospital life most in need of improvement.[5]

PRACTICAL PROGRAM FOR DEVELOPING GOOD TONE

I have described hospital tone as a product of three elements: (1) the purposes of the institution, derived from psychiatric principles and embodied in the hospital standards (which may be formally defined or existing by tacit recognition); (2) the degree of personal adjustment in employes, determining their ability to accept the standards and to translate them into action, and (3) the degree of integration among employes which permits them to work in harmony toward the common goal. I shall now present a program centering in turn around each of these factors.

[2] "What we do know is that much more important than its structure, its equipment, its location, more important even than its affiliations . . . is the spirit that prevails in it [the mental hospital]."—Karl Menninger, The Future of Psychiatric Care in Hospitals, Mod. Hosp. **64**:44 (May) 1945.

[3] "There is one group that is the most powerful factor of all [in curing patients], the ward nursing personnel."—William A. Bryan, Administrative Psychiatry, W. W. Norton & Co., New York, 1936, p. 72.

[4] "The nurse and the attendant are the nucleus of the therapeutic organization of the institution and their personal relationships with the patient are of the utmost significance."—William A. White, *ibid.*, p. 135.

[5] In line with this explanation, whenever I use the word "employe" it will refer to the attendant and may or may not refer to other employes. This vagueness is maintained in recognition of varying local conditions. For example, in some hospitals it may seem wise to conduct an orientation program exclusively for attendants while other hospitals may find such a program equally useful for nurses, farm hands, maintenance men and others in any possible combination.

Inculcating Standards Through Educational Program

Need for an Orientation Course: General awareness of good standards demands a sound educational program. It is important that the program begin when the employe first arrives at the hospital. He is then ready to form attitudes that may remain relatively unchanged throughout his stay. This is the period when the employe is most amenable to suggestion and intensive effort should be made to provide the right sort of suggestions through an orientation course. It should last at least a week, possibly as long as a month.

It may be argued that the hospital is so short of help that new employes can't be spared from the wards even for a day, but this argument defeats itself when an untrained employe makes a poor adjustment to the job and quits or is fired in a few days. Moreover, it will probably be found practical after the first few sessions to assign the employe to part-time ward duty so that the training course can proceed in the light of practical experience.

Defining Hospital Standards: One of the first tasks in orientation involves a definition of standards to lend direction to the educational program. It must be recognized that hospital standards are fluid and in constant need of redefining. This is so because they require acceptance by employes before they can be expressed in action.

Acceptance demands that they have real meaning for employes, and this meaning can best be acquired at the very time when they are first defined. All employes should feel that they have arrived at the standards by the aid of their own judgment. This should be done in group discussion wherein prevails an air of open inquiry.[6] This is far preferable to the transmission of a rigid, albeit desirable, set of ethics in an authoritarian manner.

Contents of Orientation Course: The orientation course should serve to acquaint the employe with a brief history of psychiatry so that he can appreciate his hospital in its broader setting. It should describe organization within the hospital so that the employe can understand how other departments are prepared to cooperate with him in helping his patients.

Administration building of Norwich State Hospital, Norwich, Conn., where the author served in the Civilian Public Service Program.

The course should interpret mental illness to the employe, opening the way to a dynamic understanding of the patient which is necessary for sympathetic care. It should relieve the initial anxiety of the employe by teaching him what to expect of the patient and how to protect himself in an emergency. Finally, the orientation course should teach the employe the actual nursing technics that he will be expected to use on the wards.

Importance of Discussion Method: Throughout the orientation program it must be remembered that the important thing that is being imparted is not so much the knowledge as the attitudes. They will be expressed on the ward in a thousand ways unimagined at the training sessions. With this in mind, it is important that the same air of open inquiry prevail that recommended itself for the definition of ideals. This atmosphere[7] can be created most readily through group discussion; this method should be used wherever possible. When it is necessary to deliver lectures, they should be ameliorated by a discussion period at the end.

Lecture Series and Advanced Training: Having helped the employe to start his work with a set of healthy attitudes, the hospital should make every effort to keep these attitudes alive. The routine of the job is likely to dull initial sensitivity and wear thin the action-compelling nature of original ideals. Also, new problems are likely to come up that require a reinterpretation of original ideals.

These needs call for a continued educational program. The deadening effect of routine can be combated by capitalizing on the employe's interest in the people with whom he is working. He can be brought to a deeper understanding of his patients by increasing his knowledge of psychiatry. This can be done by occasional lectures on the

[6] "The development of a common standard for ethical conduct should be on the basis of open inquiry."—Arthur E. Morgan, The Small Community, Harper and Brothers, New York and London, 1942, p. 31.

[7] The preferability of a democratic atmosphere over an autocratic atmosphere for purposes of morale was experimentally demonstrated by Lewin, Lippitt and White and recorded under "Patterns of Aggressive Behavior in Experimentally Created 'Social Climates,'" Journal of Social Psychology **10**:271-299. 1939.

psychoses and by referring him to books and pamphlets that he might be expected to understand.

A regular series of lectures and discussion groups should be instituted, meeting perhaps monthly. Besides discussion of psychoses, they might include latest research developments, special nursing technics or even discussion of social problems like juvenile delinquency.

The development of such a program should follow the needs sensed among employes and might best be directed by an educational committee including attendants in its membership. Again it must be emphasized that the main function is to keep healthy attitudes alive and almost any topic discussed in the light of psychiatric principles and in an atmosphere allowing full participation by the assemblage should be of value.

Improving Personal Adjustment of Employes

Personnel Selection: The first step toward a well-adjusted employe group is to hire persons who are as emotionally mature as possible to start with. Actually, not much selectivity is possible while wages remain low, hours long, food poor, housing drab. Anything that can be done to improve working conditions will help to raise employe caliber.

An important item among working conditions that is not often stressed is the availability of recreation facilities. A hospital that takes the trouble to provide such facilities is contributing to an important part of the employe's life and thus has a valuable asset for attracting and holding personnel. It is a particularly important project when the hospital is located some distance from a population center.

Along with providing physical facilities, the hospital should help organize a recreation committee among interested employes, contributing the services of a recreation leader as part of his regular work.

Insofar as selectivity of personnel is possible, it should be on the basis of the applicant's ability to accept the ideals of the hospital and to carry them out in practice. The qualities necessary could perhaps be determined by the hospital's psychology department and a personality inventory devised, along with a test for detecting the desired traits in applicants. Even when the manpower shortage is acute, some minimum standards should be set up in this fashion so as to eliminate some of the hopeless misfits who aren't worth the time employed in their hiring and firing.

Professional Society for Attendants: The establishment of a professional society for attendants would effect a tremendous improvement in the quality of ward nursing personnel. We have the example of doctors and nurses to prove how professional status raises the level of individual responsibility and facilitates the universal application of a high code of ethics.

The attendant's duties involve such important responsibilities in the therapeutic organization as to demand men of professional caliber. An encouraging step in this direction is the statewide program under way in Ohio involving general conferences with attendant representatives from each mental disease hospital to lay the foundation for professional organization.[8]

Clinical Training, Nursing Affiliation: Some hospitals have improved the quality of their ward nursing personnel by accepting various groups on a temporary training basis. The most prevalent practice is that of having nursing schools affiliate at the hospital but it is equally desirable to institute clinical training programs for ministers, social workers, educators and college students. These programs should be considered primarily for their educational value to the outer community but they may also provide interested and enthusiastic people for ward service who not only do their own job well but help keep regular employes on the alert.

Personal Counseling: Even when mental disease hospitals are able to obtain the services of fairly well-adjusted people throughout the institution, there still remains the problem of minor maladjustments in personality working themselves out at the expense of the patient. Personal problems which arise occasionally in everyone's life are a source of trouble on the job, especially when working with people.

Industry has begun to attack this problem by calling in the psychiatrist to set up a counseling program.[9] The mental disease hospital already has the psychiatrist on the premises and, if it is a progressive hospital, it has a psychology department to back him up. These resources should be utilized for conducting a counseling program to which employes can be directed for guidance in solving personal problems.

It may be argued in understaffed hospitals that psychiatrists cannot be spared away from work with the patients but it is precisely in those understaffed places that more responsibilities are thrust upon the ward nursing personnel and that it becomes increasingly important that they be well integrated. Thus, it should be seriously debated whether the psychiatrist cannot extend his services more effectively to the patients by spending part of his time in counseling with their attendants.

Integration Among Employes

The establishment of harmonious relationships in the working group depends in part upon the emotional needs that every man brings to his job. Men crave the respect of their fellows. In so doing, they seek a feeling of adequacy, of having something to contribute, and they require recognition for their contribution.

Men seek also to identify with a group, finding security in a sense of belonging. These are social needs, more or less common to all men and thereby separate from the psychological needs which stem from individual maladjustment and require the attention of a counselor.

Personnel Department: These needs should be formally recognized in hospital organization just as they are recognized in modern industry.[10]

[8] This program is being initiated by Dr. Attilio Laguardia, assistant commissioner of mental diseases in Ohio.

[9] For a comprehensive discussion of how the psychiatrist can improve personal adjustment to the job see "A Theory of Mental Hygiene in Industry," Surgeon Bruno Solby, Mental Hygiene, July 1945, pp. 353-371.

[10] At the end of their research, Roethlisberger and Dickson concluded that "there is a need for the explicit recognition and systematic application of a specialty which is addressing itself to the adequate diagnosis and understanding of the actual human situations . . . within the factory." Management and the Worker, Harvard University Press, Cambridge, Mass., 1943, p. 591.

Progressive corporations have called in psychiatrists to set up a personnel department through which the job is tackled.[11] The success with which they have met in solving this problem for industry would indicate that the time is ripe for psychiatrists to perform a similar function in their own citadel, the mental disease hospital.

Besides aiding in the adjustment among individuals in recognition of their emotional needs, a personnel department also functions to abet good adjustment between groups. Almost inevitably, potential conflict exists between groups by virtue of the differences between their specific purposes.

One good example in the hospital is the variance of point of view between the medical and business branches. There is a need for some neutral agency to maintain effective coordination in compliance with the broad purposes of the institution. The personnel department is equipped to perform this function.

Conference System: I have discussed how the individual's emotional needs affect the development of harmony in the working group. Dr. William A. Bryan expressed this problem succinctly as that of harmonizing personal goals with the purpose of the organization. He then went on to say that "the best way to formulate such common purposes is through group thinking and discussion."[12]

This way of group thinking and discussion is essentially what is meant by the conference method. It involves bringing people together to formulate policies in democratic session rather than having an executive make the decision and pass it on to his subordinates. It is a much better method than the latter for fostering group loyalty and for encouraging individual responsibility.

When the conference method is used in mental disease hospitals, it is usually confined to executive functions. It should also be extended to the level of ward nursing personnel. I shall describe how it might be extended to the attendant for development of his potentialities and utilizing his services to the fullest.

Ward Conferences: The working group of primary importance for the attendant is that directly concerned with ward nursing, including the doctor, the supervisor, nurses (if any) and other attendants. It would be well for these people to meet in conference in the ward office regularly, perhaps two or three times a week for half hour sessions. There they would be able to thresh out problems and formulate ward problems in a democratic atmosphere designed to promote mutual responsibility.

This group should serve as the primary unit of communication, the doctor being on hand to convey information from the medical staff and the nursing supervisor conveying information from the director of the nursing department.

Control exerted through such channels avoids the resentment, rebellion and reluctant compliance which an authoritarian system breeds. Each member of the group feels that he has a voice in making decisions and so feels personally responsible for carrying them out.

The core of good attendant care is respect for the patient as an individual. Such respect depends partly on good will and partly on understanding. Often a friendly attitude grows out of understanding so that both of these qualities can be fostered by helping the attendant gain as complete a picture of the patient's condition as he is capable of gaining. This can be done in the ward conference by discussing individual patients with the psychiatrist doing the interpreting.

Case histories should be made available for these sessions. Occasionally patients can be called in for an interview. The whole procedure can do for the attendant what the staff conference does for the doctor in presenting a well-rounded picture of the patient.

Obviously, these conferences would entail additional work for the psychiatrist but this should be compensated for by increased attendant alertness through which the psychiatrist can extend his attention to the patients as he never would be able to alone. Also, in these conferences attendants can be trained in comparatively simple skills, such as the taking of routine progress notes, and thus relieve the doctor of at least a part of his burden.

General Conferences: Integration of attendants with other parts of the hospital staff can be implemented by occasional general conferences. These can be held in larger groups of perhaps 20 or 25 attendants, but with more than that there is the danger that the meeting would cease to be a conference and become instead a lecture.

An occasional conference with someone in the occupational therapy department should be valuable for the attendant because he is responsible for supervising the work of many patients on his ward. He should become acquainted with the broad aims of the occupational therapy department and avoid regarding patient help merely as a means of getting the work done. He should become acquainted with all the activities of the department so that he can help his patients take advantage of them to their best ability.

Recreational leaders often become discouraged at the great numbers of idle patients whom they can't reach because they don't have enough help. At the same time, some of the attendants may be trying to divert these patients into recreational activities but feel themselves handicapped by lack of skill and lack of equipment. These two groups should be brought together in conference so that they can share their resources of knowledge and material on the one hand and of time and interest on the other.

A conference each with the chaplain, the psychologist and the social worker should serve to interpret the functions of these specialists to the attendant.

Inherent in this entire program outline is recognition of the emotional needs that motivate individuals. Each item of the program has been considered as it contributes to the self-respect and the social adjustment of the individual employe. The therapeutic importance of the relationship between patient and employe makes the projected changes in employe morale of the utmost significance for the welfare of the psychiatric patient.

[11] See, among other articles in psychiatric journals on the contributions of psychiatry to modern industry, "Neuropsychiatry and Placement of Industrial Workers," Mathew Brody, M.D., Connecticut Medical Journal **9**:84-88, (Feb.) 1945.

[12] Op. cit.

Chronic Disease From a Patient's Point of View

The author discusses homes for the handicapped in this article which is part two of the series

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THE exact number of chronically ill persons needing institutional care is unknown. E. T. Stephens, secretary of the Illinois Association for the Crippled, estimates that in his state they would fill larger quarters than Veterans Administration Facility at Hines, which houses 1750 patients. However, their requirements are so different that no one institution could fill them.

First, let us consider the more active section—the ambulatory who are now employed or could be if transportation and living facilities permitted. Even during the worst of the manpower shortage there were many unemployed who could have been usefully occupied.

Members of this group in the Chicago area are now raising funds for a home project because they believe it is the first essential. It is badly needed, but agreement on their needs as contrasted with the requirements of those who must have nursing care poses a problem.

Determining Location of Home

Employed handicapped persons living in rooming houses, students wishing further education in city schools and colleges, the newly rehabilitated waiting placement on jobs would all welcome a location where their needs had been considered. Since nursing and medical care are not required, the building and its location are the main consideration.

The initial expense would be great whether it involved purchase and remodeling or a new building because it must be near many employment opportunities where real estate values are high.

On the other hand, the individuals of this class pride themselves on their financial independence so that large maintenance endowments would be unnecessary. In fact, there is undoubtedly enough business and executive experience among them to run a cooperative establishment.

Desires mentioned by this class of patients point to a combination hotel and clubhouse with recreational opportunities for leisure hours. Experts in Y.M.C.A. administration or those experienced in cooperative dormitories at colleges could give valuable advice in estimating costs.

The setting need not be extravagant. Comfortable, sanitary rooms or apartments with ramp entrances and elevator service to obviate falls, community dining room, recreation rooms and library are essentials. Possibly some plan for group transportation could also be devised.

Can those needing nursing care be included in the same setup? There have been some nebulous suggestions that a building with separate wings for each category would be a good solution. In a small city where the group to be served is not unwieldy such a plan has undoubted merits. I question its efficacy in large cities like Chicago for several reasons.

First, there would be a large group of each class making a huge establishment necessary. Since the second group includes those not able to work outside the home it is not essential for them to be centrally located. Their need is rather for space for outdoor life (the ambulatory can get out to parks), so they should take advantage of lower real estate costs in outlying sections.

Second, the higher overhead per person which nursing care makes obligatory would be a source of misunderstanding, for the very nature of his struggle for independence often makes the ambulatory person overconfident so that he misunderstands his more helpless contemporary. Also, it would be unfair to expect the employed cripple to pay higher rates to keep up this dual home.

The members of our second group, which really differs only in physical condition from the first, have their own desire for independence. They must work harder for it in a more circumscribed area; therefore, I think their need is for an institution developed to give physical care, useful employment and the mental, spiritual and recreational life of normal people.

Accepting this basic need for physical care, such a home in either city or country surroundings will first provide conveniences for all possible self-help. Lifting devices for bedside and bathroom use, wide doorways and easily opened doors with no thresholds for all rooms will make wheel chair navigation easier and will save work for attendants.

The routine daily care which is essential to good health should not consume too much of the day. Therefore, any aids that increase self-help should be utilized. Treatments or periodic checkups should be scheduled in advance so as not to interfere continually with the primary occupation of the resident of the home.

To Build a Well-Rounded Life

Most of the homes I have studied seem to have developed from the old "homes for the aged or indigent." Physical care is provided under more or less stringent rules and regulations. But there is seldom any attempt to help the resident build a well-rounded normal life even in the homes that accept young persons.

To expect the average handicapped individual who is not acutely ill to spend a lifetime concerned mainly with physical care, a hit-or-miss occupational program, plus the recreational programs arranged by outsiders, seems abnormal. Small wonder if he becomes uncooperative and critical and "institutionalized" in the worst definition of that term.

It is assumed that cleanliness and balanced diets are part of any mod-

ern institutional plan. So I shall not dwell on that aspect. But let me emphasize the need for private rooms. Several consultants, in such homes or hoping for accommodations in a future one, have stressed the need for privacy in which I heartily concur. For short periods in a hospital the ward has definite advantages, but how many normal persons would care to be constantly surrounded by roommates not of their own choosing? And no matter how congenial one's friends or how gregarious his nature, there is a need for periods of personal privacy. This is particularly true in a permanent location where the individual is encouraged to have a definite aim in life.

My hypothetical home would be permeated by this ideal. Therefore, an immediate effort would be made to help each new resident find his talent and develop it. Perhaps some of the handicapped members of the home who show aptitudes for leadership could be trained as counselors for others.

Many of the duties of the home could be done by the more active members. Every possible position should be filled by a handicapped person. With these demonstrations of successful adjustment, the new resident will have an immediate incentive to plan a work schedule for himself.

The rare individual with a definite goal and the ability to achieve success will need only encouragement. But the less imaginative and talented will need help in uncovering his capabilities and developing his skill. Occupational therapy will occupy a strategic place in the life of the home.

Offer Avenues of Self-Support

Skill in arts and crafts will be developed under occupational therapy guidance leading to marketable articles. The sheltered workshop programs now in operation may be studied to determine other possible occupations. Business courses would enable members to assume positions of responsibility in keeping books and job records of the workers. Considering that some of the members of the home are already trained and have had experience, it should be possible to find many avenues of self-support open even in the limited surroundings of the home.

Skill in arts and crafts under occupational therapy guidance leads to marketable products, provides contacts outside the home. Photograph from the Central Service for the Chronically Ill, Chicago.

Furthermore, as a part of the community in which the home stands, there will be opportunities for some contacts outside it. Hospitals and sheltered workshops have developed programs coordinated with industry permitting work to be done by the disabled. Under proper supervision this would furnish additional jobs in the home.

Jack and his sister Jill become dull creatures if work is all there is to life; therefore, the recreational opportunities of the home must be varied. These should include a chance to participate in play, not just programs arranged by outsiders. Facilities should permit even the bedfast to get to recreation rooms where they can play at cards, checkers and quiz games. Game tournaments, home talent programs, parties and hobby shows are some suggestions for recreational activities that could be managed by the residents.

Of course, many educational opportunities can also be recreational when congenial groups meet as hobby clubs. Reading circles, "writers and scribblers," music, art, camera and stage fans and the collectors can combine fun and pool their knowledge to advantage.

The spiritual side of life is usually important to the handicapped and regular services should be held by a chaplain of broad sympathy and understanding. Those who cannot participate in interfaith services should be allowed to make their own arrangements to attend churches in the community or have private or group services at other hours. Fanaticism and proselyting must be discouraged, of course. If arrangements can be made for wheel chairs to be taken to neighborhood churches it will enable many to attend services and social activities.

As far as possible the home will take its part in the community and not become a place in which to segregate its cripples. Interest in civic affairs should be encouraged. Perhaps it can arrange to serve as a polling place, enabling its residents to vote.

Some Capital Needed

Many suggestions have been made by individuals I have consulted as to how a home of this sort could be organized. Since most of its prospective residents are without resources, large entrance fees seem impractical. To make the project completely cooperative each resident would need some capital, so it seems advisable to suggest that some supervising agency make the initial attempt at organization. One practical suggestion for a start was the following:

Many smaller hospitals in suburban communities have found it difficult to comply with regular hospital standards under present conditions. Medical staffs were depleted as more doctors went into service. Graduate nurses for supervisory positions are still scarce, but the buildings are often well adapted for the use of the handicapped, thereby requiring little change. Perhaps it would be possible to make satisfactory arrangements to rent or purchase such an institution if a survey could be made.

An Education in Psychiatry

is an essential part of the nurse's equipment

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WE ARE hearing much today about psychosomatic medicine. The war brought into high relief many manifestations of this age-old problem of interaction between mind and body. Industry is beginning to manifest intelligent appreciation of the effect of frustration, mental tension and emotional conflict on the productiveness of the worker.

In the shadows of civilian life, we find a large army of patients who have gone from practitioner to practitioner, from clinic to clinic seeking relief from bodily ailments whose unrecognized origin lies in emotional maladjustment. In the darker background are those who infrequently visit the clinic or doctor's office but who worry along through life with complaints and difficulties that are rooted and nourished in the soil of emotional maladjustment.

Children Are the Victims

These situations tend to produce unhappiness and ineffectiveness. In the foreground of the picture appear the children reared in a home environment of poor health and emotional stresses and in a social environment of uncertainties, tensions and confusions. Small wonder is it that such children early show behavior disturbances and organic symptoms that rest on an emotional basis.

The nurse who has understanding of the rôle emotions play in influencing behavior, together with insight into the effect of her own emotional reactions in the patient-nurse relationship, is much better equipped to take her rightful place in the rehabilitation of these individuals—in the home, the hospital, the out-patient department, the doctor's office, the industrial plant and the mental health or child guidance clinic.

The great and steadily increasing number of psychiatric patients, for whose admission our communities are building and rebuilding capacious institutions, constitutes a major sickness problem. Who gives nursing care to these patients whose number is stated to comprise more than half the total of all hospital patients in our country? The shocking inadequacy of one registered nurse in an institution housing more than 2000 patients belongs to the days of the nineteenth century when the early schools of nursing in this country were being established. Yet this situation is reported to exist today in more than one state hospital.[1]

It is true that the war made a bad situation worse in respect to the qualitative and quantitative measure of nursing service in our mental disease hospitals, but even in the best of times there was a woeful lack of well-prepared psychiatric nurses and a still greater deficiency in the number of nurses equipped to teach psychiatric nursing.

During the last three years, the hospital admission rate for patients with nervous and mental disease has been progressively increasing. In 1942 the total average census of patients in all hospitals in the United States was 1,126,028; of this number, 609,773 were classified as "nervous and mental."[2] On Dec. 31, 1942, there were 1297 schools of nursing in the United States "meeting minimum requirements set by law and board rules."[3] In round figures 45 per cent of these schools did not offer any clinical experience in psychiatric nursing to their students. The accompanying table permits us to examine these figures a little more closely as they relate to the six states having the largest average census of hospital admissions for nervous and mental disease.

These figures, however, merely tell us that clinical experience in psychiatric nursing is provided or not provided. We do not know the length of the course or anything regarding the conditions under which it is given except that it meets the approval of the board of nurse examiners in the state. When an elective course is given we do not know the extent to which the elective privilege is utilized.

Many Courses Shortened

Under the stress of an accelerated basic program in nursing education, it is probable that many affiliating courses in psychiatric nursing were shortened. It is also true, however, that schools that participated in the United States Cadet Nurse Corps plan were urged to include psychiatric nursing in the accelerated program. Also, some mental disease hospitals are offering programs in psychiatric nursing for the senior cadet period, but the glaring fact remains that many of our mentally ill patients who should receive the benefit of expert nursing care are being cared for, and were before the war, by ill-prepared unskilled people.

Three of the states referred to in the statistical analysis are in the East, two are in the Midwest and one is in the western section of the United

[1]Fitzsimmons, Laura W.: An Orphan Among Today's Professional Services: Psychiatric Nursing, Hospitals **18**:53 (December) 1944.

[2]Hospital Service in the United States, J.A.M.A. **121**:1015 (March 13) 1943.

[3]A List of Schools of Nursing Meeting Minimum Requirements Set by Law and Board Rules, National League of Nursing Education.

CLINICAL EXPERIENCE IN PSYCHIATRIC NURSING

	STATE A	STATE B	STATE C	STATE D	STATE E	STATE F
Average Census: All hospitals	167,704	80,934	75,128	55,688	71,572	52,537
Average Census: Mental Disease Hospitals	97,242	45,753	43,765	31,547	30,486	29,558
Students in Schools of Nursing	10,348	10,131	7,127	5,444	3,199	5,943
Students in Schools Offering No Clinical Practice in Psychiatric Nursing	610	4,695	3,343	1,355	1,602	1,981
Number of Schools Offering Clinical Practice in Psychiatric Nursing	9,156	5,218	3,478	2,047	1,551	3,501
Students in Schools Offering Elective Clinical Practice in Psychiatric Nursing	582	203	104	2,042	.....	146
Students in Schools That Did Not Answer	.....	15	202	.....	46	315

States. All of these states have produced leaders in the nursing profession. Some of our finest schools of nursing are located in these states, schools that have pioneered in the establishment of high standards of nursing education and in the growth of our nursing organizations. In only one of these states does the record of achievement in providing clinical experience in psychiatric nursing approach a really high attainment.

The observation may be made that many of the patients in mental disease hospitals are ambulatory, well hospitalized or chronically ill and not in need of expert nursing care. I am in accord with this point of view; a number of patients can be cared for by trained attendants with a well-prepared, registered nurse in charge of the unit or service. There remains, however, the large number of newly admitted and acutely ill patients, as well as those with intercurrent surgical and medical illnesses, for whom expert professional care should be provided.

In summarizing this discussion of need, it may be said that every nurse graduated from an approved school of nursing should have a background of sound elementary preparation in psychiatric nursing in order that she may give more intelligent nursing care and health teaching to patients of all age groups in whatever field of nursing she may practice; that she may participate intelligently and actively in public education relative to mental disease and the care of the mentally ill, and that she may help in meeting the desperate need in our state mental disease hospitals for good nursing care of our patients.

In the basic nursing program the course in psychiatric nursing is well placed if it occurs after the first fifteen or eighteen months. It is important, however, that the psychiatric aspects of the nursing care of all patients receive thoughful consideration throughout the course in nursing arts and are emphasized in all clinical nursing courses. In planning the content of the course in psychiatric nursing, the classes in psychiatry must be developed in accordance with the needs of the student, not "watered down" from the abundance of medical psychiatry.

Trained Instructors Needed

The teaching of nursing in the classroom and hospital wards must be conducted by nurses equipped with experience in psychiatric nursing and preparation for teaching. The ward experience must be planned to include intelligently supervised practice in the care of a wide variety of psychiatric disorders.

This brings us to our second consideration. *How is this need for psychiatric nursing education to be met?* On the surface it seems as though the answer is a simple one: make psychiatric nursing a requirement just as medical nursing and surgical nursing are considered essential parts of the basic course. Establish more affiliations in our state hospitals and, presto, the problem is solved. The hurdles of reality have been cleared in one broad jump!

As we view the situation a little more realistically, we look first at a mental disease hospital in which we might establish this affiliating course; we see the buildings in which patients are housed, and we see the patients representing a wide range of psychiatric disorders. We take a look at the budget which has been pared to provide the minimum in custodial care. We note the isolation of this hospital within its community; the absence of any kind of teaching program; the paucity of professional personnel; the overcrowding of patients and the lack of working equipment and we ask ourselves, is this to be our starting point?

The answer may be a negative one for the present; we may decide to turn to a hospital in a neighboring state which already has an affiliating course and temporarily obtain an affiliation. Meanwhile, through the board of nurse examiners, the State League of Nursing Education and other professional organizations, physicians and our interested public, we may start a program of public education and seek financial aid in establishing an affiliating course which, on the basis of careful study, we believe should be arranged in a selected hospital.

Please note the phrase, *on the basis of careful study*. A study of the need of the state for a particular program in psychiatric nursing education, together with a survey of available educational resources, should precede all attempts to establish courses. Not every mental disease hospital should try to offer an affiliating course, or a postgraduate course, or a basic program in nursing, or supplementary

courses for graduates or courses for attendants.

The establishment of any professional program in psychiatric nursing should be worked out cooperatively among the state hospital, the state department under which it functions, the board of nurse examiners and other professional groups. Sufficient funds must be made available in order that a well-prepared faculty can be maintained and that suitable teaching facilities and living and working conditions can be provided. There must be a cooperative attitude to this new venture on the part of hospital personnel and a willingness to work together to the end that through this enterprise better care will be provided for the patient.

If our state hospitals are to fulfill an increasing educational responsibility in nursing or other professional fields and realize their greatest usefulness in the community, there must be less public and professional apathy toward mental illness; the public must know the needs of the mental disease hospitals and be alert to the value of the hospital to the community.

There should be a closer relationship between the state hospital and the general hospital, much closer professional relationships between the personnel of the state hospital and that of other hospitals. This is especially true in nursing; nurses from the psychiatric hospitals should identify themselves actively with those from other hospital groups and the public health field, particularly in the work of our nursing organizations.

Each has much to learn from the other, and the large body of alert, informed nurses has much to contribute to the promotion of intelligent, sympathetic public understanding of the needs of the mental disease hospitals and to the awareness of the help these institutions should extend to the communities they serve, particularly if they maintain well-organized and active out-patient departments.

In summarizing, we can meet the need for the provision of psychiatric nursing education in part in the following ways:

1. Intelligent emergence from varying degrees of indifference regarding the nursing situation in many of our state hospitals, the right of every student nurse to a course in psychiatric nursing and the psychiatric nursing needs of all patients wherever located.

2. Lending our active support to the establishment of such administrative and educational standards in state hospitals as will be conducive to the better care of patients and the maintenance of appropriate educational functions.

3. Determining cooperatively the kind of educational program most needed, *i.e.* (a) an affiliating course; (b) a program for senior cadets; (c) a postgraduate course for clinical nursing specialists, head nurses, supervisors or teachers; (d) the strengthening of an already existing approved undergraduate program; (e) supplementary courses for graduates who have had no psychiatry; (f) refresher or institute courses for those who wish to be brought up to date in certain areas of psychiatric nursing, and (g) courses for attendants.

4. Working cooperatively in the establishment and maintenance of the kind of educational program agreed upon.

In the world of war, nurses carried heavy burdens both in military and in civilian life. In the world of peace, we will assume new and large responsibilities. The health needs of our own country are bound up with those of other countries and nurses must be prepared to play well their part in building a better world.

An understanding of the psychiatric aspects of nursing is an essential part of the nurse's equipment for the challenging and varied opportunities that await her; not the least of these opportunities lies within the mental disease hospital.

The Cobbler to His Last

I REMEMBER the story of a hospital executive who approached one of his staff surgeons asking permission to perform one of the operations scheduled for the following day. The surgeon was taken aback and was amused by this request and reminded the administrator that it requires years of training and experience before a physician becomes a competent surgeon. The executive's reply, in substance, was: "I know that, doctor, but I consider myself as competent to perform a surgical operation as you are to administer a hospital, so in the future, will you be considerate and understanding enough to let each of us stick to his last."

This particular surgeon had been guilty of doing what clinicians sometimes do—wittingly or unwittingly interfering in the administration of the hospital. Our executive might have explained to the surgeon that it also takes many years of training and experience before a hospital executive becomes expert in his field.

When it seeks an executive, the board of trustees usually canvasses the field and then selects the best available candidate to fill the position. Once the trustees have made their choice and convinced themselves that it is a wise one, they must support him when he is acting in the best interests of the hospital and its patients. The policy of the hospital is formulated by the governing board assisted by the executive and it, in turn, holds the executive responsible for seeing to it that this policy is carried out.

Yet we hear of instances in which staff members rebel when they are asked to follow administrative routines. Their favorite response, when they are asked to follow a routine which to them as individuals does not seem just right, is a withering "There is too much red tape around here." Everybody is impatient with "red tape" and, when the expression is applied diagnostically rather than therapeutically by a respected member of the attending staff, it has wicked connotations for the unthinking listener. It promptly throws the executive on the defensive and, if he is caught off-guard, he may have another problem on his hands.

It is a first-class trick of administration to know precisely how to keep every worker, professional or nonprofessional, clinical or administrative, sticking to his last.—JOHN F. CRANE, *assistant director, Montefiore Hospital, New York City.*

Tuberculosis is a general problem

and general hospitals must help solve it

HERMAN E. HILLEBOE, M.D.
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IN A general hospital a modern tuberculosis service can be of great advantage for everyone concerned and of no serious disadvantage. Such a service benefits the hospital, the staff, the patient and the community. The conventional objections to such a service in the general hospital are no longer valid. Health education has markedly reduced public prejudice. Professional hospital groups are aware of the need for training in tuberculosis — and want it under optimum conditions of personal protection and high standards of patient care.

It Is No Longer Irremediable

Tuberculosis is no longer always a chronic irremediable disease, to be set aside as a condition not warranting the highly organized facilities of a general hospital. Survey x-ray examinations of millions of persons reveal that this case-finding method makes it possible to discover two thirds of all infections (65 per cent) in the minimal stage. Such patients often require only short periods of hospital care and many need only regular out-patient care.

Hospital insurance has made millions of citizens aware of general hospital facilities and these persons, when ill with tuberculosis, want care under the supervision of local physicians in local general hospitals. More patients than before can pay for all or part of tuberculosis care because, in minimal disease, the required period of disability does not always exhaust the patient's financial resources.

The United States spends more than $100,000,000 annually to maintain approximately 90,000 sanatorium beds, and yet another 50,000 beds are needed immediately to provide proper care for the already reported cases of tuberculosis.

Through mass radiography thousands of new cases are being found each year. Some provision must be made to care for these newly discovered cases and, certainly, until sanatorium facilities can be expanded, it is the general hospital that must function importantly in the service of community public health.

MASS RADIOGRAPHY

Mass radiography is large-scale x-ray examination of population groups to screen out unsuspected tuberculosis. New photofluorographic x-ray equipment employing miniature film makes it possible for a single examining unit to handle from 500 to 800 persons a day. In the last five years more than 12,000,000 military personnel and probably 6,000,000 civilians have had chest x-ray examinations by this method.

On the basis of such thorough study, we know for the first time that from 12 to 15 persons in every thousand of the population have active or inactive reinfection pulmonary tuberculosis. Accordingly, there are more than a million persons in the United States with tuberculosis. Health departments have official reports of only one third that number, so there remain within the general population thousands of diseased persons who are unknowingly spreading tuberculosis to others and are destroying themselves physically.

To find these thousands of tuberculous persons and to bring them under treatment, there are in the United States today approximately 250 mass radiography x-ray units exclusive of equipment used by the Army and Navy. Twenty of these are operated by the Tuberculosis Control Division, U. S. Public Health Service, on a demonstration basis. These 20 units are staffed with division personnel and to date have conducted surveys in 29 states. When a demonstration is thus furnished, the community surveyed in this fashion is usually convinced of the value of mass x-ray examinations and establishes its own facilities for future control work.

Utilize Miniature Film

In addition to mobile x-ray units, many permanent installations utilize miniature film for routine chest x-ray. These are located in clinics, general hospitals and factories. The introduction of such units into hospitals and clinics has great significance. Routine x-ray examination of all newly admitted patients has been re-

ported in medical literature on several occasions. As high as 22 per cent of all patients admitted to some general hospitals have been found to have chest pathology.

This percentage of positive finding in a routine admission procedure is much higher than is the percentage found in the universally accepted routine blood count, urinalysis or blood serology. Therefore, from the standpoint of effective clinical diagnostic work-up, routine chest x-ray is far more rewarding in the amount of unsuspected pathology discovered than are other procedures.

Routine x-ray examination of the chest in general hospitals not only reveals a large proportion of tuberculosis but discovers the disease in population groups which cannot be otherwise screened out by general x-ray surveys—the mother, the housewife, the self-employed, the aged. Sixteen million persons entered general hospitals in 1944. Two million were admitted to obstetrical services. Women of child-bearing age have a high tuberculosis mortality, and it is difficult to assemble them for mass radiography examination. Without the cooperation of general hospitals in an x-ray campaign to screen out certain otherwise inaccessible population groups, those in greatest need of x-ray diagnosis are deprived of this service.

Not a Difficult Problem

Admission x-ray service in a general hospital is not a formidable undertaking. Modern photofluorographic units of various types are now available at moderate cost through various manufacturers. The mechanical equipment requires only a few square feet of floor space, and both installation and operation are extremely simple. Multiple automatic devices have reduced operation to mere pressure on a single switch, and total examination time has been cut to approximately one minute.

The machines utilize miniature film in rolls, so that the cost of material per examination is but a few cents. Films can be developed and interpreted in the already existent x-ray department of the hospital. Simple record procedures have been devised for the identification of films and for noting general impressions of findings. No final diagnosis is made on the basis of small films only. When these reveal abnormal shadows, the roentgenologist recommends to the attending physician that a large chest plate be made to verify findings.

A new development now in process of evaluation is the practice of taking a screening chest film without disrobing the person examined. Time required for x-ray examination is thus much reduced and better cooperation of patient is obtained, particularly that of women. Naturally, precautions must be taken to remove metal objects that will obscure the lungs' fields, such as pens, clips and other jewelry.

The advantages of routine chest x-ray on hospital admission are multiple: earlier and more exact diagnosis of all chest conditions is facilitated for the physician, whether such conditions are suspected or not; both hospital and staff avoid the frequent criticism of negligence in diagnostic work-up; hospital personnel is protected from unguarded contact with undiagnosed tuberculosis. Most important, the patient's physical welfare is markedly enhanced.

The hospital that provides a routine x-ray service gains the good will of patients, of the staff and of the community, since the last named is given public health protection through such case-finding. The service is approved by the American College of Radiology as a screening device, as it in no way supplants regular x-ray examinations. All abnormal conditions found on small film must be checked with standard sized film and with clinical and laboratory tests before final diagnosis is made.

TREATMENT AND ISOLATION

There are really four major objectives, and several minor ones, in the complete program of tuberculosis control, the first three having direct bearing upon general hospital participation in this program. They are: (1) case-finding with mass radiography; (2) treatment and isolation; (3) rehabilitation and after-care; (4) protection of the patient and family against economic distress.

We have discussed mass radiography as the acme of current methods of case-finding. Treatment, isolation and after-care (clinic care) involve general hospital provision for the known tuberculous patient.

Most general hospitals flatly state that institution policy does not permit the admission of known tuberculous patients, particularly if the chest disease is the primary reason for hospitalization. Yet statistical reports reveal that many tuberculous patients, known or unknown, are treated in general hospitals, not all of which have isolation facilities. According to a recent vital statistics report published by the Bureau of the Census, one fifth of all tuberculosis deaths, or 12,544, occurred in general hospitals of the United States in 1943. Total deaths were 57,005.

Muncipal Hospitals Pioneered

Municipal hospitals were first to realize that the exclusion of tuberculous persons is not practically possible in the general hospital, and that special provision for them within the general hospital was a logical solution. Many city and county tax-supported hospitals and many university hospitals have pioneered in the successful combination of a tuberculosis unit with the main institution and have demonstrated its many advantages.

Only a few voluntary hospitals followed this example. The "Transactions of the American Hospital Association, 1933," includes a comprehensive report on the number of general hospitals, public and voluntary, that maintain tuberculosis services. An interesting voluntary hospital plan began operation in Duluth, Minn., in 1924. The two main hospitals—St. Mary's and St. Luke's—both approved for intern and nurse training, with a combined bed capacity of 600, cooperated with St. Louis County Sanatorium and Health Department, to provide diagnostic, surgical, out-patient and hospital care for the tuberculous of the community on special hospital wards. Both pay and ward patients were admitted.

Interns, nurses and staff physicians rotated through the service and worked in close contact with the sanatorium staff. Private rooms were available for diagnostic work-up in doubtful cases. Private patients were admitted to the service and attended by their own physicians. Hospital turnover was rapid since patients were transferred to the sanatorium as beds became available, particularly

when the patient's condition indicated long-term care.

A similar plan could be worked out in other communities, particularly if there are no local treatment facilities for the tuberculous. The central location of treatment centers for the tuberculous never before loomed up as so serious a problem. In the past, a diagnosis of tuberculosis was rarely made until a patient developed symptoms and some degree of physical disability. He went to a doctor expecting to learn that something was amiss and unconsciously was prepared to accept both the verdict and the recommendations for care. If he was told he had tuberculosis and should enter a sanatorium, his reaction was not one of profound shock.

In mass radiography, many thousands of apparently healthy people pass before the x-ray machine. Many are profitably employed breadwinners with good health records. When tuberculosis is found in such an individual, and thousands of such cases are being found every year, the reaction to the discovery is very different.

Patient Can't Believe It

There is disbelief that tuberculosis could exist in a person who feels well. There is rejection of the idea of quitting work to begin bed rest at an isolated sanatorium, away from everything. In many such cases the tuberculous lesion, which could have been arrested with prompt, short-term treatment, is allowed to develop into advanced disease. This starts a long chain of unhappy events and community expenditure of funds and resources for prolonged care, aid to dependents, vocational rehabilitation and public health follow-up.

Experience has shown that a greater number of persons who learn suddenly that they have minimal tuberculosis will accept prompt treatment, if that care is available locally, under familiar conditions. As mass radiography expands, the treatment requirements of the minimal lesion patient will become the principal needs.

It is possible for any general hospital, no matter how small, to make provision for the tuberculous patient. If a special service cannot be provided, it is feasible to care for patients in private rooms under isolation conditions. In addition, almost every general hospital can arrange outpatient service and the use of diagnostic services for a chest clinic, without major physical expansion.

Clinic facilities are urgently needed for the observation and diagnosis of suspected tuberculosis and, equally important, for regular medical observation of the patient after sanatorium discharge. The former needs the specialized laboratory and x-ray facilities of the general hospital; the latter needs them also, plus facilities for pneumothorax therapy, fluoroscopy, thoracentesis and minor surgery.

There is need for more general practitioners qualified to help carry on this type of clinic supervision. Both undergraduate and postgraduate medical education must give this acute problem more consideration if the medical profession is to continue to provide leadership in tuberculosis control. Chest clinic work under the supervision of a chest specialist is one way for the general practitioner to increase his own knowledge and the all-important understanding of tuberculosis as a disease and as a social and economic problem in the community.

A small city without other outpatient facilities can easily set up a chest clinic in the general hospital in cooperation with the local health department. Such clinics need be held only at intervals of two or four weeks and, by such arrangement, the services of a chest specialist can be obtained from elsewhere if the community does not have one locally. General practitioners working with such a chest specialist over a period of a year or two will be able to carry on chest clinic and office patient tuberculosis work unaided, except for occasional consultation with specialists in individual cases.

Metropolitan areas are usually equipped with well-located chest clinics to prevent this vicious circle. Even today, however, too many cities have no facilities for treatment of the ambulatory tuberculous. The district sanatorium is too far away and the centrally located general hospital is loath to undertake the task.

The general hospital in no sense replaces the sanatorium in the care of the tuberculous who need long-term care, but it can render valuable supplementary service that is urgently needed by sharing the load of diagnostic work, clinical observation and after-care. It is hoped that soon some plan can be worked out whereby a federal-state subsidy will enable the building of centrally located sanatoriums that are fully equipped to do the whole job. Certain areas of the country are overwhelmed by a tuberculosis problem.

Only a few states have the desirable ratio of two to three sanatorium beds per annual tuberculosis death. Plans for sanatorium construction are being made in various parts of the country, which will equalize facilities for care. Even when these are completed, however, there will be continued need of the general hospital for diagnosis and treatment of tuberculosis. The general hospital has distinct advantages for certain tuberculous patients, and these advantages are so important that their utilization will continue indefinitely.

All hospitals at all times can make a major contribution to tuberculosis control by providing routine chest x-ray examination on admission of every patient, by establishing outpatient care for ambulatory tuberculous patients and by admission of selected tuberculous patients for short-term hospital care.

OTHER OBJECTIVES

Other objectives of the tuberculosis control program are of particular significance to the many professional groups concerned with individual and community health. Health education in tuberculosis, pioneered by the National Tuberculosis Association and its affiliated groups, has greater significance today than ever. The public must be informed about the disease and the new developments that make control easier.

Professional education in tuberculosis must be intensified so that more doctors, hospital administrators, nurses and social workers possess adequate up-to-date information and technical skills that are needed for proper understanding and treatment of the tuberculous. Search must be continued for a biologic or drug that will do for tuberculosis what sulfons and penicillin have done for other diseases. X-ray technics and equipment can be improved constantly.

All these objectives are being carried forward by the Tuberculosis Control Division, U. S. Public

Health Service, some of them in cooperation with other agencies. One of these that is familiar to hospital administrators is the skin-testing, chest x-ray program among student nurses, which is a cooperative project of the U. S. Public Health Service and the National Tuberculosis Association.

The federal program of tuberculosis control came into being when a separate division was created by law on July 1, 1944. The division was given funds for grants-in-aid to states so that the objectives of tuberculosis control could be more rapidly achieved throughout the entire country. Each state administers its tuberculosis control program autonomously but can call upon the U.S.P.H.S. Tuberculosis Control Division for various types of assistance in carrying out its program.

More than 50 medical officers and tuberculosis consultants have been recruited, trained and lent to states. Consultants are available in the fields of public health nursing and medical social service. Demonstration projects have been set up in various health departments to work out optimum record and reporting methods, and consultants are available to states that have problems of this type.

N.T.A. Cooperates

Intensive statistical analyses of the national tuberculosis problem have been published in cooperation with the National Tuberculosis Association. Field studies in epidemiology, nutrition, laboratory technics and socio-economic factors are in progress. However, no matter how much we learn about the extrinsic and intrinsic factors that cause tuberculosis, the real solution of the public health problem still remains one of dynamic action in the fields of case-finding, diagnosis and treatment.

Facilities for such work are expanding daily but right now the case-finding is more advanced than is provision for care. The general hospital can be adapted to take over some of the demands for care with minimum disturbance of other functions. A few far-sighted hospital administrators have demonstrated how easily this can be done and what good results can be achieved. A widespread adoption of this responsibility by the general hospital might help effect the early eradication of tuberculosis.

Star of Wonder

Christmas comes to "Our San"

ELLEN STANDING
Cincinnati, Ohio

CHRISTMAS in "Our San" was beautiful.

The candles helped to make it so and the wreath in every window. The holly, too, was part of it, festooning the walls, peeping in and out of each door as if to say, "Hello, there! I'm Christmas! In a few days now I'll come clear in and then you'll like me very much."

Mysterious packages kept coming, it seemed, from all over the world. Exclamations of delight bounced up and down the halls.

"Did you know the Strassburgers in New York City sent us a 12 slice toaster?"

"They did! Then let's have toasted sandwiches and cinnamon apple salad for Christmas supper."

Or, "A check came this morning from Mrs. Foster for Christmas greens."

"Wasn't that nice! Now we can decorate Sax Wing."

The greeting from our retired postmaster, visiting in India, helped. It cheered us to know that he remembered the nights before Christmas when, for so many years, he would telephone from the post office to say, "More packages are in so hold your tree 'till we get them out to you."

Other things, too, helped to make Christmas in Our San beautiful. The new books "Doc" Graham dumped onto the library table, the narcissus bulbs for each patient from a ladies' aid, the violin music and the songs that came through open windows, in and out of rooms, up and down the halls — "Silent Night," "O Little Town of Bethlehem," "Star of Wonder" and all the rest.

Yes, the entire community turned out to make Christmas in Our San beautiful, and so it was.

"I didn't known Christmas in a tuberculosis sanatorium could be so lovely," said Izetta, speaking of it later. But one reason was that Izetta herself had helped to make it that way. No one knew just how Izetta wormed from the doctor permission to spend Christmas at home. Ordinarily, our doctor would listen attentively and then would say, "But remember, the little T.B. bugs never take a holiday, not even for Christmas." And thus the interview would close.

Why Izetta Stayed

Yet Izetta, that year, whangdangled out of the doctor permission to go home. But did she use it? No. Just before she was to go, the patient next to her, Nancy, had a message from home saying her mother was ill. We supposed Izetta had gone, but before dinner we caught a glimpse of her down the hall.

"Why Izetta! Back already?"

"Oh, I didn't feel so good," she replied, "and, besides, what's one Christmas away from home out of all the Christmases I'll be having? And, say, do you suppose I could have a tray just for today and eat back here with Nancy?"

Yes, our Christmas star shone bright. Frank helped to make it shine. On Christmas morning we saw him walking very fast down the hall with his dust broom. He seemed in a terrific rush to get downstairs and out of sight. We guessed the reason. Not for love nor money should anyone catch him with emotion on his face.

Frank, our San orderly, had an uncanny way of noticing things that needed doing and an equally uncanny way of doing them without its

being noticed. That Christmas Mrs. Sprague was in No. 10. It was just before she had her first-stage thoracoplasty, a time when anyone would especially welcome the sight of someone from home.

Mrs. Sprague was a widow, plucky as you find them, with several children but no money. For weeks she had had no company. Frank had noticed the wistfulness on her face when we began hanging the Christmas greens. Five days before Christmas he stopped in the office and casually asked whether Mrs. Sprague's oldest daughter would be allowed in to see her mother on Christmas morning provided she had a way to get over. We said, "Yes," but checked with the boarding school where she was to find out whether it, too, would consent.

When Frank heard the reply he picked up his broom and sidled out of the office.

Christmas morning brought a fresh clean snow. The whistle of the early morning train came clearly across the fields. Frank was helping to sweep up Christmas wrappings when a taxi drew up to the San. He was in the hall outside Mrs. Sprague's room when Helen Sprague tapped on her mother's door. He glimpsed the unspeakable joy on her mother's face. And that's the reason he was in such a terrific rush to get down the hall and out of sight.

Christmas in Our San was wonderful, and the star shone right down on Peter's shoes.

During the night Peter awoke, looked over toward his shoes and smiled. Then he reached through the side of his bed, fondly touched and patted the gleaming shoes sitting on his bedside table. The nurse tip-toed over to his bed.

"See my shoes, Miss Ingersoll! See my shoes!" he whispered. "Aren't they nice! Santa Claus brought them."

"Yes, they are nice, and wasn't it nice of Santa to bring them!"

"Yes, wasn't it! I never had shoes before. Santa must have known I would like them."

"Yes, he must have. Go to sleep now, Peter, and in the morning we'll try them on."

"In the morning we'll try them on. My shoes look like Doctor Hughes' shoes, don't they!"

"Yes, they do. Good night, Peter."

"Good night, Miss Ingersoll."

Peter sighed in utter contentment and slid his hand back under the cover.

While these weren't really his first shoes they were the first he could remember. His first had been discarded four years before, soon after he learned to walk; soon after, too, the doctor discovered he had tuberculosis of the spine. Every since Peter could remember, instead of wearing shoes he had spent his time in a plaster of paris cast or on a Bradford frame.

To be sure, he had often looked at the doctor's shoes and at the nurses' but shoes for himself had never entered his mind. And when Santa had visited the nursery before Christmas to find out what the children wanted, Peter had asked for a ball, a toy dog and a train, but it certainly hadn't occurred to him to ask for shoes. Yet there they were—and Santa had brought them. Besides the toy dog, the ball and the train, he had reached into his pack again and pulled out the shoes, handed them to Peter and told him they were his very own, to wear!

There was another stir in the nursery. Sure enough it was Peter again. He was pulling the shoes just a little closer.

"Miss Ingersoll, how do you suppose Santa knew that I would like shoes?"

"Doctor Hughes may have told him."

"Maybe he did. Maybe Doctor Hughes will be out in the morning and can see my shoes. He'll like them, too, won't he, Miss Ingersoll!"

"Yes, dear, he will. Good night, Peter."

"Shoes are wonderful, aren't they, Miss Ingersoll?"

"Yes, dear, shoes are wonderful. Good night, Peter, it's Merry Christmas tomorrow."

"Good night, Miss Ingersoll. Tomorrow it's Merry Christmas and I'll wear my shoes."

Yes, Christmas left something in Our San that was very beautiful and that never went away.

Rewards for Long Service

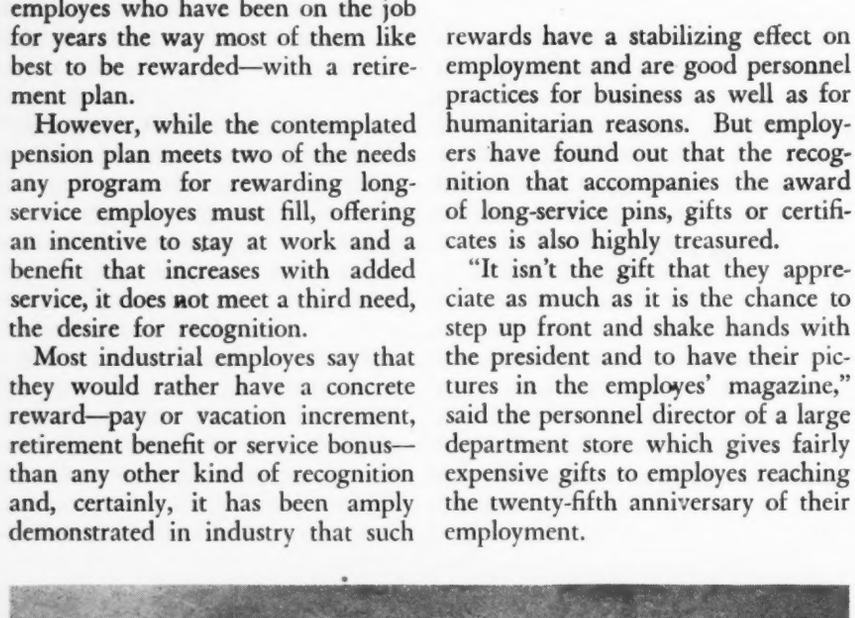
Pensions, pay increases, longer vacations, gifts, service pins and public recognition are favored methods of rewarding old-timers in these hospitals

WITH plans now in progress for establishment through the American Hospital Association of a nationwide pension trust for hospital employes, small hospitals may soon be given an opportunity to reward employes who have been on the job for years the way most of them like best to be rewarded—with a retirement plan.

However, while the contemplated pension plan meets two of the needs any program for rewarding long-service employes must fill, offering an incentive to stay at work and a benefit that increases with added service, it does not meet a third need, the desire for recognition.

Most industrial employes say that they would rather have a concrete reward—pay or vacation increment, retirement benefit or service bonus—than any other kind of recognition and, certainly, it has been amply demonstrated in industry that such rewards have a stabilizing effect on employment and are good personnel practices for business as well as for humanitarian reasons. But employers have found out that the recognition that accompanies the award of long-service pins, gifts or certificates is also highly treasured.

"It isn't the gift that they appreciate as much as it is the chance to step up front and shake hands with the president and to have their pictures in the employes' magazine," said the personnel director of a large department store which gives fairly expensive gifts to employes reaching the twenty-fifth anniversary of their employment.



This panel of pictures in the main corridor of Evanston Hospital is reserved for employes who have served the hospital for ten years.

Similarly, the personnel executive of a utilities company says that the picture and brief biography that are published in the company magazine when an employe has served fifteen years seem to mean more to most people than does the third week of vacation which is added at the same time.

Most of the small hospitals responding to questions about their methods of rewarding service indicate that both practical rewards and recognition are desirable, although in most instances the method used must necessarily be inexpensive. Among 11 hospitals discussing this aspect of employe policy, for example, eight favor the use of the A.H.A.'s employe service pin and six give public praise in the form of a newspaper story, party or ceremony of some kind to employes who have served for fifteen years.

Administrators of seven institutions think that additional vacation privileges or a salary increase should be given to employes reaching this milestone, although they do not indicate specifically that these practices are actually followed in their hospitals. Six believe that promotion to a better job, when possible, is the reward that is most desirable. Four administrators select cash bonuses or other gifts as a featured method of recognizing long service; in one of these hospitals, employes with fifteen or more years of service are given a cash present at Christmas each year. One hospital offers a unique form of pay increase as a reward for faithful service: less arduous work at the same rate of pay.

A few administrators of small hospitals are definitely opposed to longer vacations or salary increases that are awarded as premiums for length of

service, on the grounds that these basic privileges must be uniform for all employes. Service must rather be recognized either by retirement or pension benefits, gifts that have nothing to do with the regular pay rate or other terms of employment, or simply by public recognition of some kind, these dissenters hold, or else employes who have not earned long vacations or pay increments will tend to become dissatisfied.

Among the interesting comments received in connection with the Small Hospital Forum on long-service employes was this one from Vesta L. Swartz, R.N., superintendent of the 72 bed Appalachian Hospital of Johnson City, Tenn.: "I believe I can sum up our feeling in one sentence about long-service employes: Any employe who has been faithful and has given excellent service should be recognized in any way that is possible to show that he or she is appreciated; this creates an incentive to stay on the job and good will among all those employed."

Need Social Security

O. H. Overland, manager of Deaconess Hospital of Grand Forks, N. D., expresses an opinion which is widespread among hospital administrators and which found support in the action taken by the A.H.A.'s House of Delegates at the November meeting in Chicago, when he stated: "I should like to see hospitals included in the Social Security plan so that pensions would be available to hospital employes."

Rapid turnover of hospital employes, reflecting the unsettled employment conditions that have prevailed throughout the country during the war years, is indicated in the fact that several of the hospitals queried in the forum had no employes at all with service records long enough to warrant any kind of recognition.

"Our hospital has no employes with more than five or six years of service," one reply states. "No one here over five years," says another. Still others indicate that five to seven years is considered a long term of service, but acknowledge that recognition of some kind even for this limited period might be desirable.

One such statement came from L. M. Disosway, M.D., director of Hudson Stuck Memorial Hospital at Fort Yukon, Alaska.

"Conditions of living here, especially the life of the people on traplines, make it impossible for employes to stay any length of time," he says. "We have only one person on the staff who has been here fifteen years—serving as general manager of the grounds and electrician."

VOLUNTEER ACTIVITIES

The Legion Contributes

If someone totaled the funds donated annually by women's auxiliaries to hospitals, the amount would startle the women themselves, let alone the members of men's boards who are accustomed to thinking in terms of vast sums.

So it is not surprising that a national auxiliary like that of the American Legion can make impressive gifts to hospitals. A recent beneficiary is the national leprosarium at Carville, La., which is to get two new station wagons bearing the gift card of the Legion auxiliary. From the same $80,000 fund comes a number of dual control automobiles for naval hospitals for the purpose of training amputees to operate cars with safety. Three greenhouses have been set up at combat fatigue centers and a generous cash gift has permitted the purchase of material for research in prosthetic appliances for wounded veterans.

All This and Happy Birthday, Too

Even the birthdays of 75 diabetic children are remembered with a greeting card by the enterprising auxiliary of the Grace Hospital, Detroit. These women make the youngsters in the diabetic clinic and the hospital's diabetic camp their favored project. Diabetic children are joined by other hospital house and clinic patients at the annual Christmas party, also auxiliary sponsored. It will make some auxiliaries envious to learn that, in addition in sizable deposits in its various special funds, the Grace ladies have $4500 in war bonds.

Mothers Get Acquainted

One of the pleasant events on the calendar of the women's auxiliary of Evangelical Hospital of Chicago is the semiannual luncheon for mothers of the freshman class in the school of nursing. The luncheon tables are spread in the big gymnasium in the nurses' home and after an attractive meal a musicale is usually held. The freshman students themselves come in for the program and the mothers usually find the girls already well oriented to hospital routine, even though they have been in school only a few weeks at most.

This auxiliary is now engaged in raising an endowment fund which will provide one full scholarship yearly in the school of nursing. The fund will be a memorial to Mrs. Joseph A. George, late wife of the Rev. Mr. George, superintendent of the hospital. The auxiliary already has a rotating loan fund for student nurses.

Another activity sponsored by this women's group is the nurses' chorus. The women pay the salaries of the director and the accompanist.

They're Good Business Women

It is good that charitable organizations exist to utilize some of the business acumen that is latent in many wives of successful business and professional men. Some of these women could possibly outshine their husbands, given the same opportunities in the world of business.

How many new businesses can pay off their original investment in the first year of operation? One new business that has done this and has shown a neat profit is the gift shop at St. Luke's Hospital, Chicago. Probably no overhead is charged against the shop but it repaid the hospital for all the costs of installation and left a profit of $2343 the first year, of which $1951 is represented by inventory.

Two chief factors in this business record are Mrs. Walter A. Graff's committee which has chosen the stock with great discrimination and the donations of dozens of infants' sweaters and other knitted garments.

Besides the advantage of a fine location, the shop extends its service onto the private floors by means of an ingenious display cart made in the hospital's own workshop.

She Just Worked Harder

War needs inspired many women to hospital volunteer duty but not Mrs. Alfred Mack. When the war came along, Mrs. Mack just worked a little harder at the volunteer labors she had been giving Montefiore Hospital, New York City, for the last seventeen years.

Because of her long service, it was fitting that Mrs. Mack should be placed in charge of Red Cross nurse's aides at the hospital. Not long ago the hospital gave its third annual party to honor volunteers. At that time her devoted associates among the nurse's aides presented her with a gold Red Cross pin.

Purchase and Issuance

one system does both jobs well

PAUL MEYER JR.

Assistant Director-Comptroller, Montefiore Hospital, Pittsburgh

A GREAT deal has been written over the years on purchase and supply. The subject has been covered from a broad economic point of view, as well as from the rather limited one of the qualifications necessary in the successful purchasing agent. Relatively little has been published, however, to cover systematic purchase and issuance of hospital supplies and the accounting therefor, particularly as it affects a medium sized hospital. I propose to describe here details of a procedure that we have found successful at Montefiore Hospital, Pittsburgh.

The forms used are primarily of our own design (although the requisition and quotation forms were adapted from those designed by Sidney Bergman, director of Montefiore Hospital, during his tenure as assistant director at Beth Israel Hospital, Boston) and incorporate features which have been successfully used in the business world.

Logical Sequence of Work

The fundamental aim of the system is, of course, to provide a logical sequence in the steps of the purchasing procedure and to record these steps clearly with a minimum of time and error and a saving of labor. The associate aims are to control stock leakage, over-payments and under-payments, rush or emergency orders and duplication in the receiving department.

The actual organization required the integration of two distinct systems that were in effect: one that covered the issuance of supplies from the storeroom to the various consuming departments, and the other, the actual purchasing procedure from the original requisition through the final step of comparing a receiving slip with a purchase order and comparing both of these with the invoice.

I shall take up first the routine issuance of supplies on requisitions and the method adopted, but before doing so I must point out that no system, however well devised, can be successful without competent and honest storeroom personnel.

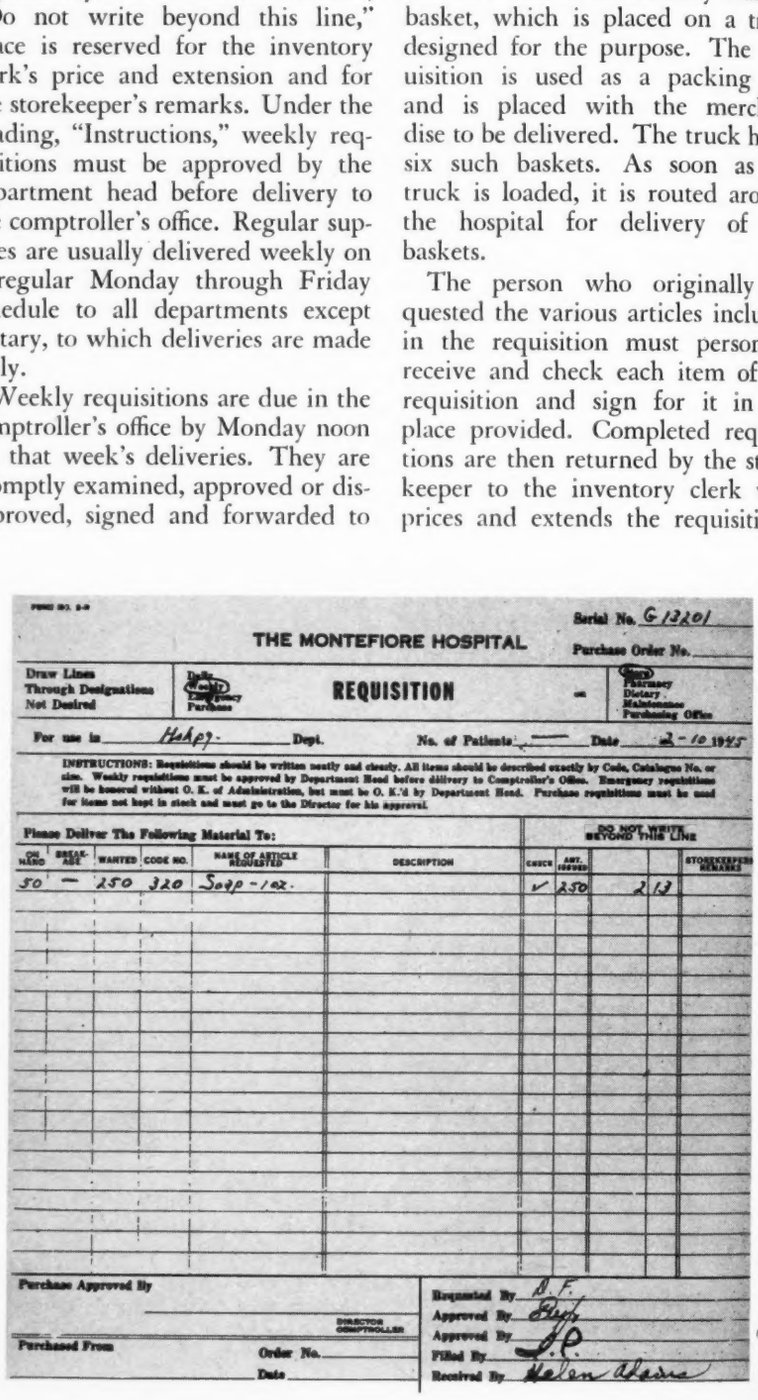
The requisition we adopted may be used for every type of supply and by every department. It covers every situation, *i.e.* daily, weekly, emergency or purchase. The possible sources of supply are listed in the upper right hand corner and the directions for routing are indicated on the left side near the top.

The headings are, we believe, self-explanatory. In a section headed, "Do not write beyond this line," space is reserved for the inventory clerk's price and extension and for the storekeeper's remarks. Under the heading, "Instructions," weekly requisitions must be approved by the department head before delivery to the comptroller's office. Regular supplies are usually delivered weekly on a regular Monday through Friday schedule to all departments except dietary, to which deliveries are made daily.

Weekly requisitions are due in the comptroller's office by Monday noon for that week's deliveries. They are promptly examined, approved or disapproved, signed and forwarded to the storekeeper for disbursement.

The storekeeper completes one requisition at a time, accumulating the various items in an ordinary laundry basket, which is placed on a truck designed for the purpose. The requisition is used as a packing slip and is placed with the merchandise to be delivered. The truck holds six such baskets. As soon as the truck is loaded, it is routed around the hospital for delivery of the baskets.

The person who originally requested the various articles included in the requisition must personally receive and check each item of the requisition and sign for it in the place provided. Completed requisitions are then returned by the storekeeper to the inventory clerk who prices and extends the requisitions,



THE MONTEFIORE HOSPITAL

Serial No. G 12201

Purchase Order No.

Draw Lines Through Designations Not Desired

Daily (Weekly) Emergency Purchase

REQUISITION

on

Pharmacy Dietary Maintenance Purchasing Office

For use in Kitchen Dept. No. of Patients — Date 2-10 1945

INSTRUCTIONS: Requisitions should be written neatly and clearly. All items should be described exactly by Code, Catalogue No. or size. Weekly requisitions must be approved by Department Head before delivery to Comptroller's Office. Emergency requisitions will be honored without O. K. of Administration, but must be O. K.'d by Department Head. Purchase requisitions must be used for items not kept in stock and must go to the Director for his approval.

Please Deliver The Following Material To:

DO NOT WRITE BEYOND THIS LINE

ON HAND	BREAKAGE	WANTED	CODE NO.	NAME OF ARTICLE REQUESTED	DESCRIPTION	CHECK	AMT. ISSUED			STOREKEEPER'S REMARKS
50	—	250	320	Soap - 1 oz.		✓	250		2 13	

Purchase Approved By

DIRECTOR COMPTROLLER

Purchased From

Order No.

Date

Requested By B. F.

Approved By Steph

Approved By J.P.

Filed By

Received By Helen Adams

posts them to the inventory cards, totals them and files them with all of the other requisitions for that particular department for that month.

At the end of each month, these requisitions are totaled by departments and a statement of these totals is prepared for the accounting department. The grand total of all of these departmental expenses must equal the total issuances from the storeroom as reflected by an adding machine tape of the issuances from the inventory cards.

It seems advisable here to introduce our inventory card system. The two cards used for this purpose are known as a "purchase record" and "stock record." The stock record, with which we are concerned at the moment, receives postings from the departmental requisitions. Headings are provided for date, order number or department, quantity received and unit price, quantity issued, average price, balance in quantity, total price and wash—the wash column being used to absorb small differences occasioned by the use of average prices in issuance.

The purchase order form is printed in sets of five copies, distributed as follows:

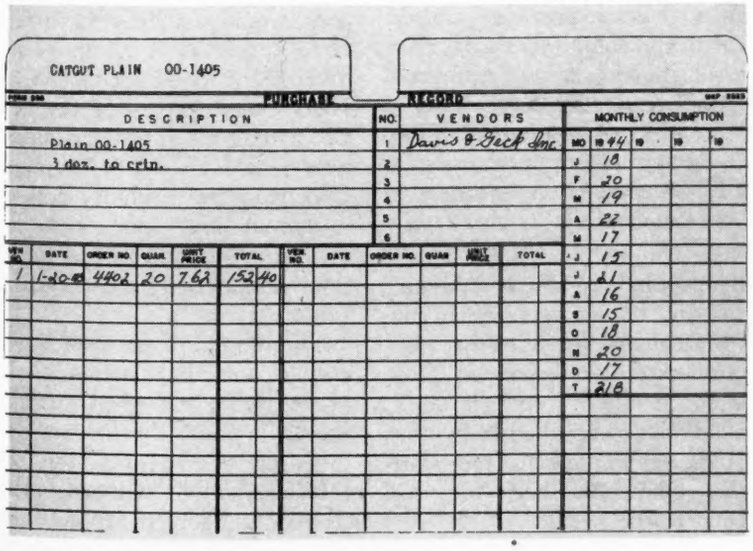
1. The original is the vendor's copy. In the upper right-hand corner is printed the request that the vendor show the numbers below on invoices, packages and credits. Compliance with this request by the vendor is not difficult to obtain and saves a great deal of the receiving clerk's time in searching for the proper order to which a shipment applies.

The space provided in the block, carrying the purchase order number, for a "requisition number" is used to indicate the serial number of the original requisition. This number and the purchase order number are identical with the serial number and the purchase order number which appear at the top right-hand of the requisition form. The use of these numbers on both the purchase order and the requisition provides a method of cross indexing.

The reverse side of the vendor's copy carries a number of conditions that obtain in placing orders which were included after a great deal of thought on the matter.

2. The second sheet in the set is labeled "purchasing department" in the lower left-hand corner and is identical with the original with the exception that it provides space for the initials of the person or persons verifying prices and calculations; space for an expense classification or code number, and space for a receiving signature. This copy is retained in the purchasing office in an alphabetical file until such time as merchandise on the order is received, when it is transferred to a permanent numerical file.

3. Sheets 3 and 5 are accounting department copies while sheet 4 is the receiving department copy. By the use of cut-out carbon, information concerning quantity and price is deleted from copies 4 and 5, both of which are forwarded to the receiving department as soon as the purchase order is written up. In the receiving department these orders are indexed numerically and filed alphabetically.


CATGUT PLAIN 00-1405

PURCHASE RECORD

DESCRIPTION	NO.	VENDORS
Plain 00-1405	1	Davis & Geck Inc.
3 doz. to crtn.	2	
	3	
	4	
	5	
	6	

MONTHLY CONSUMPTION	MO	19 44	19	19	19
	J	18			
	F	20			
	M	19			
	A	22			
	M	17			
	J	15			
	J	21			
	A	16			
	S	15			
	O	18			
	N	20			
	D	17			
	T	218			

VEN. NO.	DATE	ORDER NO.	QUAN.	UNIT PRICE	TOTAL	VEN. NO.	DATE	ORDER NO.	QUAN.	UNIT PRICE	TOTAL
1	1-20-44	4402	20	7.62	152 40						

As merchandise comes in, the receiving clerk pulls both copies from his alphabetical file, opens and counts or weighs the merchandise in the shipment, notes the quantity on both copies, notes the fact that shipment has been received against that particular order in the numerical index, forwards the receiving copy to the accounts payable clerk and the accounting department copy to the inventory clerk.

The accounts payable clerk, who has already set up the accounting department copy (which she has received at the time the order was written) in alphabetical order, removes this copy from the file for comparison with the quantities recorded on the receiving department copy. The price extensions are verified from the accounting department copy to the invoice, against which quantities are also verified. Price differences must be approved by the comptroller.

Handling Incomplete Orders

The inventory clerk, upon receipt of the fifth copy of the purchase order form, withdraws the purchasing department copy from its files, compares the quantity received with the quantity ordered and, if the shipment is short, holds both copies out for the preparation of a "back order." If the shipment is complete, the numerical index maintained in the purchasing office is marked to indicate this fact and copies 2 and 5 are then filed numerically together. If the shipment is not complete, a back order is completed in triplicate, again using the cut-out carbons so that the triplicate records neither price nor quantity. The duplicate is then sent to the accounts payable clerk and the triplicate to the receiving department, the original, of course, remaining in the purchasing department's alphabetical file, replacing the original purchase order, which has been withdrawn.

This back order form is primarily for internal use. It provides a means of releasing original purchase orders on which a shipment, complete or incomplete, has been received. This allows a purchasing department record to be included in a voucher for payment, that is, every voucher contains a record of the original purchase order and the invoice. Vouchers are thus, in a sense, complete within themselves. It is important

to note that these back orders bear the same numbers as the original purchase orders. As shipments against the back order are received, the same procedure is repeated.

Should there be occasion to alter a purchase order in any way, as to price, quantity or specifications, a fifth form, called "purchase order alteration," is provided. This form can be made up in sets of as many copies as are required, *i.e.* it is sometimes necessary to advise the accounting or receiving department of a slight change or to correct an error without notifying the vendor, or it may be necessary to reduce or raise a quantity, to cancel entirely or to notify the vendor of agreement with a price different from that quoted.

4. While all of the forms previously described have been printed, the sixth and last form in this system is a simple mimeographed sheet used for tabulating quotations. This sheet has been kept to a standard 8½ by 11 inch sheet for ease in filing and has been ruled to provide maximum space for writing descriptions and specifications and for conveniently taking down prices by telephone.

How Purchase Record Is Used

In going from item to item in our description of the forms in use in our purchasing procedure, we have omitted discussion of the top half of the inventory card called the "purchase record." Space is provided in the upper left-hand corner for a full description of the stock item. To the right of this space, six lines have been blocked off to provide a method of coding vendors. The remaining block across the top is used to summarize monthly consumption for a period as long as four years.

As orders are placed and before copy 2 of the purchase order form is filed, information concerning the order is recorded on the card—the vendor's code number, the date of the order, the order number, the unit price and the extension. When the inventory clerk is entering the receipt of merchandise on the stock record, she also checks completeness of orders entered on the record.

Supplies that must be purchased are segregated into two general classifications, *i.e.* stock and direct. Stock items are divided into: (1) general stores—G; (2) pharmacy stores—P; (3) maintenance stores —M; (4) housekeeping stores—H; (5) dietary stores—D. Direct items are those that are purchased for consumption rather than for storage and are received and delivered directly to the department requesting them. These items are charged to these departments in accordance with the expense classification of the accounting department.

No supplies or equipment can be obtained by any department of the hospital except on a properly approved requisition. Each operating department of the hospital which has the right to request supplies or equipment is furnished with a set of 3 by 5 inch cards, set up alphabetically, indicating the classification of all merchandise normally carried in stock in accordance with the foregoing code letters.

Thus, a requesting department is able to indicate on a requisition form whether merchandise is being requested from the storeroom or the purchasing office and, in addition, what section of the storeroom. Items that are desired but are not included in this set of cards must, of course, be purchased, and this fact must be indicated on the requisition.

In compiling weekly requisitions and for ease in filling them, requesting departments are not permitted to include more than one type of merchandise on any one requisition. Thus, a floor supervisor requesting water tumblers, toilet paper, soap, catheters and an electric fan would be required to request the water tumblers on one requisition, the soap and toilet paper together on a separate requisition, the catheters on a third requisition and the electric fan on a fourth.

When these requisitions are delivered to the comptroller's office for approval, they are serially numbered with the departmental code as a prefix to the serial number. Filing of an accumulation of charges, as well as the completion of orders by the storeroom clerk, is thus facilitated.

Requisitions are then separated, that is, the requisitions which contain direct items and items that must be purchased are separated from those to be filled from the stockroom. Those to be filled from stock are then forwarded to the storekeeper. Quotation sheets are then attached to the balance.

These quotation sheets are filled in down the left-hand column with the item description and specifications and across the top with a number of sources of supply for the particular items. These sources of supply are obtained from a vendor's card file which lists almost all of the vendors with whom we customarily deal by the types of product they sell or manufacture. Quotations from local firms, unless they are very detailed or lengthy, are obtained by telephone.

As soon as the tabulation of quotations is complete, the comptroller, who doubles as purchasing agent, awards the orders and the purchase order is written up. These sheets are not completed when the product being ordered is supplied on a contract basis or in those situations where the price is fixed, nor are quotations used where the possible sources are limited to a single manufacturer or vendor.

This procedure is not intended to interfere with the calls of vendors' representatives. Salesmen who call regularly are not limited to any particular day or to any particular time of day. They may not always be awarded orders at the time of their calls, but the freedom they have been granted in making their calls at any time has resulted in improved service and a better relationship between the hospital and its suppliers.

Receiving Clerk Also Storekeeper

It is important to note that no records are retained by the receiving clerk, who doubles as storekeeper. He is required to keep his storerooms neat and clean, to fill orders promptly and only on authorization and to maintain his stock in a fresh clean condition at all times by delivering the oldest merchandise first. He is subject to periodic checks, usually semimonthly, by the comptroller, who may take a tray of inventory cards from the inventory clerk to the storeroom and spot check actual quantities on hand against the quantities indicated by the perpetual inventory cards.

This system of purchase and issuance is not cumbersome and it has proved to be extremely valuable in the savings that it has enabled us to effect. A system of this nature, I believe, might without great difficulty, be adopted by any hospital.

The Aging Have a Future

MAXWELL LEWIS
Superintendent, Home for Dependents, Department of Hospitals, Welfare Island, N. Y.

THERE is in the Home for Dependents on Welfare Island, N. Y., an aging population of 1848 men and women. It may be said that few places in all the world present a cosmopolitan and heterogeneous accumulation of human souls comparable to those to be found in this home.

Admission to the home is open to dependent adults and approximately 70 per cent of the population is more than 65 years of age. Many of these people are of native stock but the majority were born in some foreign country; in fact, the list of birthplaces of our residents includes 43 foreign countries.

All Possess Some Disability

Every person on record who has presented himself for admission to the home possessed or possesses some form of physical ailment. The diagnosis of most of these cases upon admission falls in the category of "diseases of the cardiovascular system." Other diagnoses in the order of their quantitative importance are: "diseases of the nervous system generally," "diseases of the musculoskeletal system," "diseases of the eye," "diseases of the body as a whole" and "diseases of the abdomen generally and peritoneum."

Although the City Home is a public institution into which are gathered more than 1800 individuals, it should be emphasized at this point that in the conduct of the home and in the care of its people those who administer it strive for individual responsibility and attention. As far as is humanly possible every effort is made to foster among the residents a spirit of self-importance, self-responsibility and self-reliance. Perhaps it may sound like a contradiction in terms but we try *not* to institutionalize those in the institution.

Every effort is made at the very beginning to get the people out of the home and into the care of relatives, friends or other relief agencies and into employment. In 1943, 1215 persons were discharged from the institution. The greater number, 621, was sent out to hospitals, but of the other 594 who were discharged, 196 were returned to relatives and friends, some to old-age assistance, some to home relief, some to private homes and 145 to gainful employment—75 to outside employment and 70 to the City Home pay roll.

Most of those who remain in the home have neither relatives nor friends. When there are relatives in these cases, we have found that they have large families of their own and are unable to support the old person. Therefore, since there will always be many who will need the care of a public institution it becomes incumbent upon those who administer it to do so in a manner befitting good public service.

Throughout the long history of the City Home—the hundredth anniversary will be celebrated in 1946—there is every indication that those who were charged with the responsibility for the care of the residents performed their duties well and with full regard for the many needs of their old people. Perhaps somewhere along the line some may have faltered but not often or for long.

We carry on the best traditions of public service by regarding the needs of the old people as theirs by virtue not of charity but of right. Everyone on our staff, in no matter what capacity, recognizes the fundamental "rights" of the people of the home listed in the accompanying panel.

The right of freedom of movement is adhered to by having no regulation that restricts access to any place on the island so long as there is no danger of injury and it is not "off limits" because of rules made by other authorities. An individual morning and evening check is made and the presence of each individual is required then. At other times during the day each individual, able to do so, may move about the island at will. Usually, the whereabouts of each is known quite well at mealtimes. Only this restriction, if it can be considered so, is placed on freedom of movement, namely, that permission to go off the island must be sought and obtained. Few seek to leave the island and then only to visit. A record is kept of each such visit, when made, for what length of time and to whom and where.

Special Church Services Conducted

The freedom to worship, wherever, whenever and however, is recognized and observed most faithfully. There are Catholic, Episcopal and Lutheran churches and a Jewish synagogue in the home. Each of these is administered by a chaplain of the faith. These places of worship are open all day and every day. Appropriate and special services are conducted by the chaplains.

BILL OF RIGHTS FOR THE AGED

The Right to freedom of movement without interference.
The Right to worship, wherever, whenever and however desired.
The Right to have one's personal possessions respected.
The Right to maintain one's privacy.
The Right to immediate and proper medical and nursing care.
The Right to suggest improvements and to criticize.
The Right to a proper social and recreational life.
The Right to choose the type of institutional work desired.
The Right to be fed regularly with good nutritious food.
The Right to clean shelter.
The Right to proper, adequate clothing.
The Right to safety of person through proper safeguards.

Presented at annual conference of American Geriatrics Society, June 1944.

There are also individuals who seek to worship in other ways than are accorded by these churches and on such occasions we have been ready to provide places for Methodists, Baptists, Seventh Day Adventists, Christian Scientists and others. It has been noted in the home that religion and the strict adherence to its tenets become more and more an important part of daily life in the aging process.

Small, indeed, are the personal possessions of our people but no matter how insignificant these may be, it is profoundly recognized how important to each person are the few things he calls his own. A steel locker with a small compartment that can be locked is provided each resident. No official, no nurse, no employe is ever permitted to open these lockers except in the presence of the owner.

Bank Account Builds Morale

This rule is observed rigidly and it adds to the respect we show one another. The money each possesses is deposited with the property clerk and the banking procedure followed is one that instills self-importance in the depositor even though the average bank account is about $2.50.

The right to privacy is most difficult to observe in the home because of the construction of the buildings and the dormitories. Yet to the extent to which it can be fulfilled at all it is practiced. Trespassing is not permitted especially during early morning or late evening hours; bathrooms and toilets afford privacy. Screens are available for those who seek additional privacy when visited by relatives and friends. The principle of affording all possible privacy for the individual is strictly emphasized and carried out by all employes.

The resident medical staff consists of five full-time physicians and there is a visiting staff in all services, such as medicine, surgery, eye, ear, nose and throat, urology, gynecology, neurology and dentistry. Thorough physical and mental examination upon admission and then another recheck at least once each year of all individuals; daily clinics in all services; a large nursing and attendant staff; a laboratory, an x-ray division, physical therapy, and an infirmary make it quite possible for us to recognize the right of each individual to proper, immediate and adequate medical and nursing care.

The importance of the right to suggest ways to obtain better care for themselves and to criticize without fear was recognized many years ago. Each dormitory was asked to elect a delegate to a general council and this council of delegates meets with the superintendent regularly each week. At these council meetings the delegates are free to voice their opinions, their suggestions and their criticisms. Much that is good and of benefit to all the residents of the home has come from the deliberations of this council.

The democratic principle recognized here has made living in the home more wholesome and desirable. Then, too, regularly each week the superintendent conducts a "grievance" committee which acts upon charges made by the residents against other residents or against employes or by employes against residents. This committee consists of the superintendent, the superintendent of nurses and the director of the social service division. The decisions rendered are adhered to by all. It recognizes the right of the individual to be heard and that right is deeply appreciated.

The fundamental blessing of any human being is that of living in a community with his fellows with whom he can enjoy a wholesome, happy social life. Dances, teas, holiday parties, bazaars are held regularly by and for the residents of the home. No proper occasion passes without some form of social activity. For other forms of recreation there are concerts, the radio, dramatic playlets, indoor games, moving pictures and, sometimes, vaudeville. There are picnics, boat rides and outdoor games in the summer. For education there are libraries, lectures and forums arranged by the residents themselves. To all of these forms of social, recreational and educational activities they are rightfully entitled.

Soon after admission to the home and after the admitting physician has examined the new resident physically and mentally and has rendered his diagnosis, if the doctor indicates that the resident can do some form of labor, one of the social service workers points out the various kinds of jobs that can be done. Perhaps he would like to work in the dining rooms or in the kitchens. Maybe he would care to be a messenger or a bedmaker or sweeper, or, even better, it is likely that he has some hobby and would care to do some work in the arts and crafts shops.

This is the important thing—the choice is left with the resident. That right to say what he would like to do first is our guide and his privilege, a privilege we respect. The approval of the choice, of course, must rest with the doctor. The individual in most cases is limited to no more than two hours of work in the morning and two hours in the afternoon.

If proper care is to be given the aging, no right is more important than to be entitled to good, wholesome food served well and regularly. Besides the three regular meals, the resident may have beverages during the midmorning and midafternoon hours. A staff of seven dietitians plans the menus and supervises the preparation and service. Special diets are prepared and served to those for whom they have been requested by the physicians.

Food Is Pleasant and Plentiful

The breakfasts consist usually of a fresh or stewed fruit, cereal, milk, eggs, coffee, bread and butter. The lunches contain, as the main dish, a meat or fish with two vegetables, pudding, bread, butter and tea. The evening meal is a heavy soup or cereal, a green salad, cake or pudding, fresh or stewed fruit, bread, butter and coffee.

It must be quite evident, also, that if desirable care is to be given the people they have a right to be properly and adequately clothed, that the dormitories and rooms and the beds be immaculately clean and that every precaution, every safeguard be taken and enforced to assure them every freedom from bodily injury.

I have administered the City Home for ten years and it is because of this decade of contact with the aging that I feel able to say this: If it is at all possible to form a pattern of living for the aging in a public institution then the program outlined and the City Home's attitude in recognizing the fundamental "rights" of these individuals and respecting these rights have done much to assist our aging residents to attain a "future."

To See Ourselves

As Our Patients See Us

LOUIS L. ROTH

London Guarantee and Accident Company, St. Louis

HOSPITAL administrators should be particularly interested in finding out what the people who employ labor and run business houses think of hospitals and what suggestions they may have for improving hospital service.

To find out just how people are thinking, I worked out a brief questionnaire, in a rather hurried fashion, and, using a "sampling" method, sent copies to a selected group in the state of Missouri. The results were well worth the effort. So, the ideas here expressed are not really my own; rather, they are the results of this meager research.

No Crystallized Opinion

Hospital people are very lucky that there is no crystallized opinion on the subject of hospitals, their services or their physical and financial setups. This leaves it in their hands to work out and to plan. It does, however, put the responsibility squarely on their shoulders. This responsibility they must accept with a desire to please and serve those who use their facilities. If they do not, they may find the public "taking over," for the public will not stand for inefficiency in the handling of its most treasured possession, the health of a loved one!

Let us approach the problem in a businesslike manner, breaking it into three parts: (1) plant and equipment; (2) services; (3) finances.

In the first category, the opinion of the public may be summarized as follows:

1. There is a shortage in the number of hospitals, especially away from metropolitan areas.

2. The public wants hospitals to be thoroughly modern and fireproof. The architectural design can be left to experts.

3. The public wants excellent elevator facilities. (Some people want service elevators separate from passenger elevators.)

4. The public wants adequate stairways. In some cases, ramps might be used, but this, too, is an engineering problem, not a problem for the layman.

5. Proper parking facilities are sadly lacking. The public thinks hospitals should correct this promptly.

6. As to floor plans, we outsiders are not able to judge competently whether or not medical, surgical, maternity, nursery, pediatrics and other departments should be on separate floors. After all, it's your workshop. We do think there should be an isolation floor or building. We do not want to come in for an appendicitis operation and go out, minus the appendix but with whooping cough instead.

7. Equipment? Surely, the public expects you to have "the very latest," always! Sterilizers, ultraviolet lights, x-ray apparatus, refrigerators, incubators, everything you need. And your operating rooms? Well, don't think that we, the people, want anything less than the most modern and the best, for that is where you do your "precision" work. We know it must be just right. We want it that way, too.

8. You will pardon us but we think the lighting in rooms and wards is, for the most part, very poor. How about having a lighting engineer who knows the answers do some research for you? We don't know what's wrong, but it surely doesn't cheer up the patient to be in a dingily lighted room. Sunlight is probably best; maybe the architect can make each room an outside room, but that could only apply to a new hospital. Can't you improve the lighting of the old hospitals?

9. Unless there is a health hazard we laymen don't understand, we consider modern air conditioning a fine idea. Many other new comforts will become available in the months to come and these should be applied to the care of the sick, whenever practical.

10. Private bathrooms? Sure, we prospective patients love them if you will just keep the price of the adjacent rooms within reason. We can pay a bit more—but not too much.

11. Telephone service is highly essential to all business men. It boosts patient morale to be able to call the office, keeps men from worrying as they convalesce. You can keep the switchboard closed to us if the patient is too sick.

12. Radios? Well, why not let patients have them to while away the time? Ear phones are better than nothing!

Business Men Understand

Now, when we business men talk about that intangible thing called services, here is where many of you can learn from us. We, too, have to deal with irate customers, grouchy bachelors and dizzy girls. Your cross-section of the public and ours are the same, only you have to handle your customers when they are emotionally upset because of either their own or their families' illness. What is the general atmosphere surrounding your hospital? Is it like a morgue?

Presented at the meeting of the Missouri Hospital Association.

Is it unfriendly? Is it quiet and orderly? What is our impression? What do we in business want?

First, we want an atmosphere of efficient cleanliness. And we mean clean! Germs hide in dirt, don't they? We don't like germs. We don't want dirt.

Then, we should like to have friendly and intelligent handling from the admitting personnel. We want an understanding person at the cashier's window. We want a voice we could love forever on the telephone desk—you know, the kind that makes you glad you called (even though you don't find out much) or, if the news is not so good, one we won't hold personally responsible for the difficulty.

Promptness in admissions is most important in emergency cases. Industrial and other accidents slow down production and lower worker morale. Good hospital handling of accidents is talked of around the shop. It makes the workers feel more confident. We have made allowances for war conditions in hospitals and we are not criticizing, but we feel that many hospitals have failed to put enough emphasis on prompt admission and prompt attention in emergency cases.

We don't have any kick on the laundry service but what is the matter with hospital meals? Surely you have an expert dietitian in the kitchen! Sometimes it doesn't seem like it. Too often the meals are almost cold when they are brought in. Here is a place we think you need to work. Do meals have to be "tasteless"? Can't they make the patient want to eat?

We know what it costs to do the job hospitals are doing. We know we are asking you to spend still more money to add more beds, better lighting, more nurses, telephones, private baths and, perhaps, air conditioning.

We have done this very same thing in our businesses. We have found it pays good dividends. You will find the same thing. People will want to come in and that's a good thing. Maybe it wasn't during the war but, in normal times, yes. We want our people to come to your hospitals. We think they can get well much more quickly, have healthier babies, happier homes because of better health and can have minor ailments attended to before they become major. Yes, we believe in our hospitals.

Your daily charges, in most cases, are too high. All of us want to pay our own way; we don't want charity. Blue Cross and other hospital insurance plans have helped, but we need more protection.

On the whole, we do not think a hospital should necessarily operate within its earned income. The deficit can be made up by the taxpayers on public hospitals or by private endowment or subscription in voluntary hospitals, the same as in educational institutions. But, we want trained men operating them, the same as we want trained educators running our schools.

Frankly, I believe it sums itself up into this: It is fortunate that the people have the great confidence they have in hospital administrators, who are trained specialists. On the whole, your administration of hospitals is pleasing the public. There are certain things the public thinks you should study and some you should change. It is willing to leave the responsibility in your hands, but it expects you to solve the problems.

I believe a bold and broad program to meet this demand can and will be met by hospital executives. You will find industry, business and the general public happy to assist in any plan you may develop that will satisfy the apparently growing need in all communities.

Nursing Is in Danger

SOMEBODY remarked of Florence Nightingale that she was a sharp-tongued, fierce virago battling for reform with ruthless passion. This may be a little strong, but so was Miss Nightingale. She interfered continually with what today is described as "politics" and did not hesitate to procure ventilation of official incompetence, being quite unconcerned at the risk of so-called scandal.

It would be interesting to trace the exact point in history which led to the perversion of her story into the mushy and phoney fiction of the "Lady of the Lamp." One thing is certain—she would have trounced those present leaders of the nursing profession who adopt the conventual vocation attitude. I know of few nurses who share the opinion of one of the great Dames of the nursing profession who informed her junior colleagues that they were "God's own little gentlewomen" and proceeded to warn them that any combination on their part for the advancement of professional and economic status was improper and, by inference, against His wish.

The nursing profession has been in a position of increasing danger for the last decade. Today it is a danger not only to itself but to the nation, too, by reason of its inadequacy in numbers and organization. The nurses, just as the doctors, can scarcely expect anybody else to put their house in order for them. What is usually called the rank and file is ready to support any strong and active lead. The pity is that those who are already in a position to settle nursing on an equal footing with other women's professions content themselves with appeals founded on a platitudinous sentiment and shy with a skittishness unbecoming to their years away from the words "salary" and "working conditions." If they would intersperse Milton along with their pious thoughts, I would recommend these words of his:

"I cannot praise a fugitive and cloister'd vertue, unexercis'd and unbreath'd, that never sallies out and sees her adversary, but slinks out of the race, where that immortal garland is to be run for, not without dust and heat."—The *Lancet*.

Oak Ridge Clinics

and how they grew!

VIDEL HUDLER

Associate Hospital Director
Oak Ridge Hospital
Oak Ridge, Tenn.

THE Oak Ridge Hospital and Clinics at Oak Ridge, Tenn., were built, equipped and staffed under war-time conditions. The problems encountered were not basically different from those of any other hospital of comparable size but the speed with which the facilities developed engendered special problems that will be of interest to other institutions.

Title to the land upon which the community of Oak Ridge was built was not acquired until late in December 1942. It was then simply a collection of several hundred farms aggregating about 90 square miles. When it is realized that by November 1944 there were more than 75,000 residents in addition to some 20,000 workers who were employed here but who lived off the area, some idea can be gained of the pressure under which medical and hospital facilities had to be provided to take care of such a large number of people to whom other medical facilities were, for all practical purposes, unavailable. The speed of growth of a city of this size is without a parallel in the history of this country.

700 Patients a Day

One of the busiest and most important departments of the hospital was its clinics which were treating almost 400 patients daily in November 1944 and more than 700 daily in August 1945. The clinics gave emergency care to both the plant personnel and the residents and the usual treatment for surgery, medical, obstetrical, eye, ear, nose and throat and pediatric cases.

Patients frequently came during their working hours and loss of time in waiting to be treated meant an economic loss to them. Moreover, to many of them a visit to a clinic was a new experience and they came with serious misgivings. In order to give the best care it was necessary to establish procedures that would expedite treatment, make the patients feel at ease and acquaint them tactfully with the necessary rules and regulations.

In November 1944, the procedures in the clinics had three outstanding weaknesses:

1. There were long periods of waiting before patients could see the doctor.
2. There was confusion among the patients and hospital personnel.
3. The cashier receipts were considerably below expectations, being less than 50 per cent of the total of cash treatment given.

To shorten the waiting time of the patients a thorough study was made in each clinic to find the cause.

It was found that while the clinics received some of the charts promptly, others took much longer, sometimes hours, to be located. The average time of delivery of all charts in the medical and surgical clinics during the study was twenty-nine minutes and a fraction. There was no general plan of prompt collection of charts from the hospital stations, doctors' offices, business offices and clinics. In a few days, with the cooperation of everyone handling charts, the delivery time was reduced to eight minutes.

Patients were seen in the order of the arrival of their charts rather than of the patients' arrival at the clinic. This was remedied by recording the time of the patients' arrival in a ledger and calling them in that order. The charts, even though delayed, were placed in order of the time recorded in the ledger.

While patients were not kept waiting very much longer in our clinics than in those of other hospitals in the surrounding country, the complaints were many. What could we do to improve the situation? There was restlessness among them because of the economic loss sustained while waiting. After deliberation we realized that some of the fault lay with the personnel of our clinics

A study of the receptionists showed that they all went about the business of registering patients, checking charge slips and placing charts in doctors' boxes in a perfunctory manner and showed nothing in the way of interest in or concern for the welfare of the patient.

The first step toward winning the cooperation of the patients was to gain their confidence. To begin with we set about to improve the type of receptionists.

We interviewed all applicants for receptionists' jobs, choosing those who made a good appearance, were experienced in meeting people and had a pleasant personality besides being efficient at desk records.

Put in Training Prgram

We put into effect a training program, holding conferences for all departments at which basic instruction was given. Later, conferences were held with receptionists of the various clinics, taking up the problems peculiar to each. They were informed about the general progress being made and of any improvements they helped to accomplish. They were given a picture of the importance of the part they played in connection with the organization as a whole and what they could do to raise the standards. By this means we gained their interest and they worked steadily and untiringly toward that end.

The receptionists learned that chart and record work at their desks was only part of their responsibility. They began to feel the change for the better in the attitude of patients, who recognized the fact that they were being called in order of their arrival. Something more far-reaching was that their new interest in patients reacted decidedly in favor of the hospital.

Patients, although they occasionally waited as long as previously, were in a pleasant mood because they knew that everything possible was

being done to shorten their waiting time and to increase their personal comfort. (The clinics by this time were treating close to 600 patients daily.)

Having effected better handling of patients through improvement of chart delivery and in selection and instruction of clinic personnel, we turned to the business end of the hospital, namely, collection of fees. We found that improper handling of charge slips by our receptionists was one of the chief causes of our loss of cashier receipts.

In this hospital there are four classifications of payment only one of which calls for cash payment.

1. Pay.
2. Compensation cases where workers are injured in performance of their duties and treatment is financed by insurance companies. The doctor at the plant in which the injury occurs examines the patient and if he thinks it necessary for him to see a hospital physician sends a referral slip with him.
3. Oak Ridge Health Insurance. This is a form of health insurance for workers employed in Oak Ridge only.
4. The military and military dependents living on the area receive treatment free of charge.

Might Not Collect Fee

If through an error, the charge slip for cash payment was made out under classification 2, 3 or 4, it usually meant that a great deal of time was spent in making the correction with the possibility that the bill would not be collected.

Pay Classification. So much money could be lost through wrong classification that we set about at once to train all personnel handling patients' charge slips. This was done by a written plan of procedure, meetings with receptionists and, later, by supervision of various clinics with correction at the time the mistake was discovered.

Compensation. The plant doctors did not always send the referral slip with the patient and for a time the patient was allowed one visit without this slip. Later, when many cases proved to be not compensable, and as a consequence the insurance companies refused payment, we tightened our supervision and paralleled this with more urgent requests for referral slips from the plants.

When a patient arrived for treatment with no referral slip, the receptionists were required to call the plant and have someone make a special trip to bring the referral slip to the hospital. A ruling was made that if the slip did not arrive with the patient the fees were to be paid in cash and the money refunded when the slip was presented. This took time on the part of the receptionists from other more important duties.

Finally, a meeting of all plant doctors was called by Lt. Col. Charles E. Rea, medical director of the hospital, at which a uniform referral slip was agreed upon. The importance of the referral slip with relation to the patient's treatment was discussed and it was agreed that this slip must accompany the patient on his first visit to the hospital from the plant.

Oak Ridge Health. A similar problem presented itself in following up Oak Ridge Health members. A number of charge slips classified as Oak Ridge Health were not honored for the following reasons:

1. Patients were not listed as members (although they had proof of payment in the form of pay-roll deduction).
2. Cards were obsolete. (The worker had left the plant which had given him his membership card. This card automatically expired at the termination of his position but instead of surrendering the card, the patient had continued to use it.
3. Carelessness of the patient in failing to bring his membership card to the clinic.

We began by checking these cases with Oak Ridge Health headquarters. This took many hours a day and interfered with other work of receptionists, which was necessary to keep up with the fast-growing organization of the hospital.

It was decided to call a meeting of Oak Ridge Health and hospital administrators. At this meeting the following regulations were put into effect: (a) all new members would receive a permanent membership card within two weeks; meanwhile they would carry a temporary card acceptable for treatment at the hospital; (b) all voided cards would be picked up at the plants at the termination of the workers' services; (c) members who failed to bring cards to the hospital were to pay cash and would be allowed a refund if they presented their membership cards at the cashier's window within twenty-four hours.

Military. There then remained the problem of distinguishing the military dependents from civilians of the community. This was done by distributing a special card from military headquarters to all military dependents living on the area. They were required to pay cash unless they had this card of admission.

The next step was a training program for the public. We gave out written information on our plans and asked for cooperation. Each new patient on being registered was also given information verbally. This brought an immediate response and the patients complied with our rules pleasantly on the whole.

Why Service Was Poor

Obviously, one group which plays an important part both in the hospital and in its connection with public relations is the telephone department. A study of this department showed unnecessary work being placed on these operators in the following respects:

1. Excessive calling over the page system.
2. Many outside calls from the hospital stations holding up the lines.
3. Impatience on the part of employes who were unwilling to wait their turns for free lines.
4. Calling clinics and hospital stations by name rather than by extension number.
5. Close alliance with the information department which distributes mail and packages. The hospital personnel came into the office, handled mail and packages and was in general so noisy that the operators were disturbed. They were short in their answers on the board and sometimes rude.

In November 1944, at the beginning of our program, the situation was such that improvement was imperative.

Changes made were as follows:

1. By order of the medical director page calls were reduced to emergencies only.
2. Outside calls from clinics and stations were discouraged, thus reducing the demands on the lines.
3. A second switchboard was installed and an additional operator was employed, thus eliminating most of the delay in obtaining a wire.
4. While some still called for clin-

ics and stations by name, most of the personnel learned the numbers of departments most frequently called. The operators were pleased with this improvement as they now had time to learn the numbers of all stations, a total of 180. The operators also had time to listen to the callers' requests and made an effort to connect them with the proper departments.

5. The switchboard and information departments were remodeled.

At this date complaints relative to telephone operators are almost a thing of the past. This plan of reorganization was painstaking and detailed but it paid dividends in the end. From an average of less than 50 per cent in November 1944, the receipts of April, May and June 1945 reached an average of 83 per cent. Some of the remaining 17 per cent was paid by patients on return visits to the hospital.

Doctors, nurses, receptionists, pages, the business office, telephone department and patients gave us complete cooperation. The program could not have reached its peak of efficiency unless everyone had worked together.

Sought Better Collections

In July 1945 a conference of hospital and Army administrators was called to review the progress. The program in effect had brought the desired results with one exception. There was still an unpaid total of about 12 per cent which had to be placed with collectors. To collect this cost the hospital more than the money collected. In order to lower expenses entailed with collectors and to increase collections within the hospital it was decided to convert to a pay-as-you-enter system.

This meeting was held July 28, 1945, and I was directed to plan and put the project into effect August 15, 1945. The conversion proved successful in that cashier receipts increased from an average of 83 per cent to 96 per cent.

We look back over these months of continuous reorganization with a feeling of pleasure and satisfaction, knowing that all who had an opportunity to take part in the plan were happy to participate. The end result has been that the care of patients has improved and the organization has functioned smoothly as a whole with happiness and comfort to the patients and higher returns in fees.

More About Community Boards

THE article, "Business" *vs.* "Community" Boards, which appeared in the Trustee Forum in October has prompted a response from Clearfield Hospital, Clearfield, Pa., regarding the organization of its board.

"To me," writes J. A. Moberly, administrator, "the method of election is the essence of democracy and the attainment of proper community understanding. Several years ago it was decided that, to attain the greatest public interest in the hospital, the public should be given a method of expressing its desires relative to the basic policies of the hospital. Consequently, the by-laws were studied for possible revision. After much study the following policy was adopted:

" 'Members of the Clearfield Hospital Corporation shall consist of annual members who contribute at least $5 per annum to the treasurer of the hospital or to the Clearfield Community Chest.

" 'The affairs of the Clearfield Hospital shall be conducted by a board of directors, five of whom shall be elected each year to serve three years, by the members of the corporation at the annual meeting to be held on the fourth Tuesday of June each year. In case of a vacancy, the board shall elect a successor to fill the unexpired term.

" 'Suitable notice of the annual meeting shall be given not later than two weeks before the date of the annual meeting to the members of the corporation. Members shall be determined from the subscription list of the Clearfield Community Chest and from the record of contributions paid to the hospital.'

"Prior to the annual meeting the president of the board appoints a nominating committee consisting of three members not from the board. The nominating committee then nominates to the board twice as many individuals as there are vacancies to be filled. The committee first ascertains the willingness and desire of the nominee to serve. It tries to obtain nominations which will best represent local interests. This slate of nominees is then sent to each member with the notice of the annual meeting. At the annual meeting additional nominations can be made from the floor, thus completing the process of giving everyone an opportunity to participate.

"Such procedure is ideal for a small community. It is perhaps not adaptable to a large hospital.

"What are the results of such participation? The annual meeting is well attended. Information about the hospital and its management is presented to the public intelligently. It is surprising the interest the election arouses.

"As a result, the board of directors of the Clearfield Hospital does, as your article suggests, reflect the spirit of the community. Of the 15 members of the board, we have the following representation: one represents converting and manufacturing; one represents public utilities; two are retired businessmen; one is a certified public accountant; two are attorneys; one represents labor and the community chest; one, an insurance man, represents a neighboring community using the facilities of the hospital; one is an electrical engineer; one is a refractories superintendent; one is a banker; one is a hotel man, and one is an automobile dealer.

"The only female member of the board represents the Department of Public Assistance and the many women's organizations of the community. Indirectly included in this representation are many other organizations, lodges, service clubs, churches and faiths.

No Dead Wood on This Board

"This board is active. There is no 'dead wood.' Each member takes his duties seriously and gives concrete suggestions at board meetings. The various committee meetings are usually attended 100 per cent. At the same time this board does not go over the head of the administrator in the management of the hospital.

"In other words the board, the staff and the administrator work together with a minimum of contention. All efforts are exerted toward the betterment of the hospital and the hospital's relations to the public."

Administrators

James U. Norris, superintendent of Woman's Hospital, New York City, for twenty-six years, retired on December 1. He was succeeded by **Dr. Karl Klicka** who was recently discharged from government service and who, prior to the war, was assistant director of Grasslands Hospital, Valhalla, N. Y. In addition to heading Woman's Hospital, Mr. Norris was chief executive officer of Rockefeller Institute for Medical Research, Polyclinic Medical School and Hospital and Presbyterian Hospital, rendering a total of forty years' service to the four New York institutions. He is a life member of the American Hospital Association and a former president of the Hospital Association of New York State, the Greater New York Hospital Association and the Hospital Bureau of Standards and Supplies, Inc.; of which he has been a director for twenty years. Mr. Norris, whose early experience was in engineering and construction work, plans to devote part of his time to making surveys and acting as a consultant in hospital planning and organization.

Albert H. Scheidt has gone to Michael Reese Hospital, Chicago, as director of administration. Mr. Scheidt, former administrator of Miami Valley Hospital, Dayton, Ohio, was recently discharged from the Army Medical Administrative Corps.

Col. David Littauer, M.C., has been named director of Menorah Hospital, Kansas City, Mo., to succeed **Dr. Edward Kirsch.** The latter has been appointed director of Lebanon Hospital, New York, succeeding **Cmdr. Jack Masur,** U.S.P.H.S., who has been on leave of absence from Lebanon Hospital and who has been selected as hospital consultant to the Federation of Jewish Philanthropies in New York.

H. E. Tubergen, formerly of Jackson, Mich., has gone to Kansas City, Mo., to become head of Bethany Hospital.

Julia L. Dougher, superintendent of Hudson City Hospital, Hudson, N. Y., is retiring after many years' association with the institution.

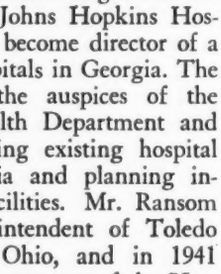
Dr. W. G. Nealley, who is completing his thirty-fifth year as superintendent of Brooklyn Hospital, Brooklyn, N. Y., is retiring in June.

Mother M. Regina, formerly superintendent of Bethania Hospital, Wichita Falls, Tex., has returned to Mother Frances Hospital, Tyler, Tex., as superintendent. When the city of Tyler leased the new hospital to the Sisters of the Holy Family of Nazareth in 1937, she was the Superior Provincial who negotiated the contract. In addition to the foregoing hospitals, Mother Regina has been in charge of the Nazareth at Mineral Wells, Christ the King at Vernon and Loretto at Dalhart, all in Texas.

John E. Ransom has resigned as assistant director of Johns Hopkins Hospital, Baltimore, to become director of a survey of state hospitals in Georgia. The survey is under the auspices of the Georgia State Health Department and will involve studying existing hospital facilities in Georgia and planning increases in those facilities. Mr. Ransom is a former superintendent of Toledo Hospital, Toledo, Ohio, and in 1941 served as executive secretary of the Hospital Council of Greater New York.

Verne Pangborn, assistant administrator of the University of Iowa Hospitals at Iowa City and secretary of the Iowa Hospital Association, has resigned to become business manager of Coe College, Cedar Rapids, Iowa.

Dr. A. F. Branton, director of the Willmar Clinic at Willmar, Minn., and executive secretary of the Minnesota Hospital Association, has resigned both these positions to become administrator of the Baroness Erlanger Hospital in Chattanooga, Tenn. Doctor Branton went to Chattanooga December 10.



Leslie Reid, assistant administrator at Presbyterian Hospital, Chicago, has been promoted to administrator, succeeding **Herman Hensel** who has retired. Mr. Reid has served as auditor at Presbyterian Hospital and as comptroller at Albany Hospital, Albany, N. Y.

W. W. Sherman, administrator of Itasca County Hospital, Grand Rapids, Minn., and president-elect of the Minnesota Hospital Association, moved December 1 to Albert Lea, Minn., where he will be administrator of the Naeve Hospital.

Myrtle B. Skoog, formerly head of the Immanuel Hospital, Mankato, Minn., has become assistant administrator of the Leahi Hospital in Honolulu, T. H.

Omer Maphis, administrator of Deaconess Hospital of Freeport, Ill., has been appointed administrator of the Kenosha Hospital at Kenosha, Wis.

Ethelyn B. Thornton has been named administrator of the Citizens Hospital, Talladega, Ala., to succeed **Virginia Windham.**

Mrs. Ruth Raschke has been appointed superintendent of nurses at Bryan Memorial Hospital, Lincoln, Neb., to succeed **Mrs. Mildred Domingo.** Mrs. Raschke has been instructor in nursing arts at Bryan Memorial for several years.

Department Heads

James A. Hamilton, who has been director of New Haven Hospital, New Haven, Conn., for seven years, has announced his retirement to take effect January 1. Mr. Hamilton will join a group of other hospital administrators to establish a hospital consulting service. In 1939 Mr. Hamilton was named president of the American College of Hospital Administrators and in 1942 was elected president of the American Hospital Association. He will continue as lecturer in hospital administration at Yale University.

Louis Slatin has been promoted to the position of personnel executive at Montefiore Hospital for Chronic Diseases, New York City.

R. E. Lyons has been named purchasing agent at Saginaw General Hospital, Saginaw, Mich. Prior to joining the staff of the Michigan hospital, Mr. Lyons was associated with Methodist Hospital, Gary, Ind., in the same position.

Mrs. Hertha McCully, formerly executive housekeeper at Wesley Memorial Hospital, Chicago, has accepted a similar position at Shadyside Hospital, Pittsburgh.

Miscellaneous

Dr. Lawrence Kolb, formerly chief of the mental hygiene division of the United States Public Health Service, has been appointed deputy medical director of the State Department of Mental

(*Continued on Page* 164)

HEADLINE NEWS

V.A. Surgeon General Outlines New Plans for Hospitals

By EVA ADAMS CROSS

WASHINGTON, D. C.—Separation of professional services from administrative functions is the keynote in the new program of the Office of the Surgeon General of the Veterans Administration, according to a statement of that office November 23.

The separation is carried on down to the lowest level of the medical service. In each hospital there will be an administrator or manager, an assistant manager and three chiefs—of medical service, administrative service and special services. Major General Hawley places emphasis on the use of specialists in every major field of medicine.

Introduction of teaching in Veterans Administration hospitals is being stressed by the surgeon general. Appointment of 49 resident physicians in the Hines Veterans Administration Hospital has been authorized. A school of psychiatry is to be started in an Army General Hospital which is to be taken over by the Veterans Administration. Dr. Paul Magnuson is already getting postgraduate education under way at Hines.

Generally speaking, every qualified physician in the United States will be eligible to treat veterans in some kind of plan to be introduced on municipal, county or state basis. Out-patient clinic contracts have been made with private clinics to examine and treat veterans. A fully staffed mental hygiene clinic is already in operation in Los Angeles. In partial operation are such clinics in half a dozen other cities.

In addition to Doctor Magnuson, the following specialists have accepted appointments with the Veterans Administration: Dr. Daniel Blain, neuropsychiatric service; Col. Esmond Ray Long, tuberculosis (on loan from the Army); Walter Bura, prosthetics and amputee rehabilitation; Lt. Col. Brian B. Blades, thoracic surgery; Col. Robert G. Spurling, neurosurgery, and Col. Robert M. Zollinger, general surgery.

D. S. M. to General Kirk

WASHINGTON, D. C.—Maj. Gen. Norman T. Kirk, surgeon general of the Army, has been awarded the Distinguished Service Medal. The award was made in recognition of his outstanding leadership in directing the largest medical department in the history of the United States.

Dr. A. P. Merrill Wins Modern Hospital Award With Suspect-Nursery Article

Dr. A. P. Merrill, superintendent of the Home for Incurables, New York City, is the winner of this year's MODERN HOSPITAL Gold Medal Award. Doctor Merrill's prize-winning article, "Suspect Nurseries—A Case History of Experience at St. Luke's Hospital, Chicago," appeared in The MODERN HOSPITAL for January 1945, shortly after he moved to New York from St. Luke's, where he served as medical director for three years.

Honorable mention certificates were awarded to Dr. Eugene Walker, superintendent, Springfield Hospital, Springfield, Mass., and Jennie F. I. Dixon, director of social service at Springfield Hospital, for their article, "Chronic Disease Ward," which was published in the June 1945 issue.

Other articles that figured in the voting by the judges included "Psychiatry Comes of Age," by Dr. D. E. Cameron, March 1945, and "The Army Learned These Lessons," by Lt. Col. Henry W. Brosin, May 1945.

For Most Valuable Contribution

The MODERN HOSPITAL Award is made each year for the article which makes the most valuable original contribution to the field of hospital administration. Standards for judging value include the improvement in hospital service that the contribution promises, its practicality and breadth of applicability.

Doctor Merrill's article described a new technic for the control of infectious diseases of new-born infants, a problem of increasing importance to general hospitals in view of the steadily increasing number of hospital births and the comparatively slow progress that has been made in reducing infant mortality in the first few days of life. Doctor Merrill's procedure brings established principles of preventive medicine and communicable disease control to the maternity floor, providing for the isolation of infants who are suspected of being ill or who are in the incubation stage of disease. Detailing every step that was taken in establishment of the suspect infant nursery at St. Luke's, Doctor Merrill also discussed the common practices which permit the spread of infection in maternity departments and explained the specific effort made to meet each of these problems. Preventive measures were aimed at eliminating airborne, as well as hand-borne, infections. Pictures, floor plans, infant mortality tables and a complete bibliography helped the reader to a full understanding of the subject.

Doctor Merrill, who is 36 years old, was graduated from the Leland Stanford University School of Medicine in 1935. He served as assistant superintendent of San Francisco County Hospital from 1938 to 1940, when he went to St. Luke's as assistant director, a title he held until his appointment as medical director in 1942.

The Walker-Dixon article was a report on ten years' experience in operating a chronic disease ward in a general hospital. The article reviewed special problems in providing needed care for all the main classifications of chronic illness, for young people with chronic diseases and for elderly patients. Cooperation with the Massachusetts Department of Public Welfare in the social service follow-up of patients was an important part of the program, which covered a total of 814 patients over the ten year period reported by Doctor Walker and Miss Dixon.

Members of the committee of judges making The MODERN HOSPITAL Award were chairman, Dr. Arthur C. Bachmeyer, director, University of Chicago Clinics; Dr. Robin C. Buerki, dean of the graduate school of medicine, University of Pennsylvania; Dr. Basil C. MacLean, director, Strong Memorial Hospital, Rochester, N. Y., and William J. Donnelly, Greenwich Hospital, Greenwich, Conn.

House Passes Bill to Up Nurse Pay

WASHINGTON, D. C.—The Navy nurse pay bill, S. 1491, to adjust the pay and allowances of the Navy Nurse Corps has passed the House and is now on the Senate calendar. The Committee on Naval Affairs has reported the bill out favorably. The purpose of the bill is to entitle members of the Navy Nurse Corps, during the period beginning July 10, 1944, and ending six months after the termination of the present war, to: (1) credit of service for purposes of advancement to higher pay grades and resultant increased subsistence and rental allowances payable to officers having dependents, and (2) retirement pay for disability incurred in line of duty.

New Intern-Resident Plan Is Designed to Aid Assignment of Veteran Medics

Revision of the war-time intern-resident program to lengthen internships to twelve months and speed the assignment of returning medical officers to residencies is being accomplished under the reconversion plan announced by the Procurement and Assignment Service in November. Briefly, the new internship program provides:

1. Continuation of present internships to July 1, 1946.

2. Appointment of senior students graduating in March to internships beginning April 1, 1946.

3. Extension of these April 1 internships to July 1, 1947, to bring them into line with the twelve month program.

The residency change stipulates that all present residents and assistant residents having reserve commissions will be called to active duty by April 1, 1946, and their places are to be filled by returning veteran medical officers. Hospitals have been urged to place veterans on residency staffs at the earliest possible moment, if necessary arranging for the release of present reserve officer residents to make room for them.

According to Maj. Gen. George F. Lull, Deputy Surgeon General in the Army, there will be no difficulty in obtaining residents and assistant residents from among discharged officers. "Up to date, more than 14,000 of these men have been separated," General Lull told The Modern Hospital. "Many of them gave up residencies to come into the service and desire to continue their training. All the larger hospitals apparently have a very satisfactory number of applications for these residencies and as more men leave the service there will be more material available."

Commenting on the internship program, General Lull said:

"Under the new program the present class of graduates will receive fifteen months' intern training rather than nine, so that the expiration date of their internship will fall on the last day of June. This, of course, means an overlapping of three months between the next incoming group and the present incumbents. From what we hear, most hospitals will take care of this, but, if they can't, we will be glad to take off their hands the men who have completed nine months' service. We believe that the plan proposed by the Procurement and Assignment Service will work satisfactorily for all concerned."

"The change is a welcome one," Dr. Basil C. MacLean, director of Strong Memorial Hospital of Rochester, N. Y., commented, "for it restores a measure of order to a program of intern training which has been badly demoralized during the last three years. Until further notice, it is assumed that opportunities for further training as assistant residents and residents will be available only to interns who are physically disqualified, women interns and ex-servicemen."

Maj. Gen. George F. Lull to Join Staff of A.M.A.

Maj. Gen. George F. Lull, Deputy Surgeon General of the Army, has been appointed assistant secretary of the American Medical Association, the board of trustees of the association announced December 5. General Lull will take office January 1 when he will retire from active Army service after more than thirty years as an Army medical officer.

Commissioned into the medical corps in 1912, General Lull served in France with the AEF as Commanding Officer of a base hospital. He has also served terms as chief of laboratory service and director of laboratories at Walter Reed General Hospital, professor of bacteriology at the Army Medical College and medical adviser to the Governor General of the Philippine Islands.

As Deputy Surgeon General, General Lull has been director of personnel and chief of the statistical division for the Office of the Surgeon General.

Decentralization to Cut Red Tape in V.A.

Washington, D. C.—The need for multitudinous reports from 150 veterans' hospitals to the central office of the Veterans Administration will be virtually eliminated under the decentralization program now in progress, according to General Omar N. Bradley. At present, 97 veterans' hospitals and 53 regional officers are reporting directly to the administrator.

When decentralization is completed, the 13 deputy administrators located in principal cities over the nation will consolidate information and report directly to the administrator.

Robinson E. Adkins, previously announced as deputy administrator for the New York office, has accepted the position of assistant administrator for medical administration in the central office of the Veterans Administration in Washington.

DOCTOR BLACK DIES

Dr. Benjamin W. Black, medical director of the Alameda County Institutions and superintendent of Alameda County Hospital, Oakland, Calif., died at his home in Oakland December 1. He had been ill for about two months, first with nephritis and then pneumonia, but had left the hospital and was apparently recovering when he was stricken.

One of America's best known hospital administrators, Doctor Black was a past president of the American Hospital Association and the Western Hospital Association and for many years a member of the editorial board of The Modern Hospital. As director of county institutions, Doctor Black was responsible for the operation of a fully developed system of hospitals and related agencies, in addition to his duties as superintendent of the county hospital itself. He was a specialist in the field of mental and nervous disease care and a fellow of the American Psychiatric Association.

In 1938, Doctor Black was the choice of a citizens' committee in Chicago appointed to search the country and recommend a chief administrative officer to reorganize and manage the Cook County Hospital, a post he later declined.

Doctor Black was born in Utah in 1887. He was educated at the University of Utah and the University of Chicago and took his medical work at the Medico-Chirurgical College of Philadelphia. He was graduated in 1916 and soon afterward entered the Army Medical Corps. Leaving the Army in 1919 with the rank of lieutenant-colonel, Doctor Black joined the medical staff of the U. S. Public Health Service and became state supervisor for Utah. In 1924 he was appointed medical director of the U. S. Veterans Bureau, a post which he held until he went to Alameda County in 1928.

Doctor Black's interest in the American Hospital Association dated from the time of his service with the Veterans Bureau. In 1933 he was elected vice president of the association and served as an associate editor of *Hospitals*. He was named to the board of trustees in 1936 and served terms as president-elect and president in 1939 and 1940. He was an active member of many committees of the association and of the American College of Hospital Administrators.

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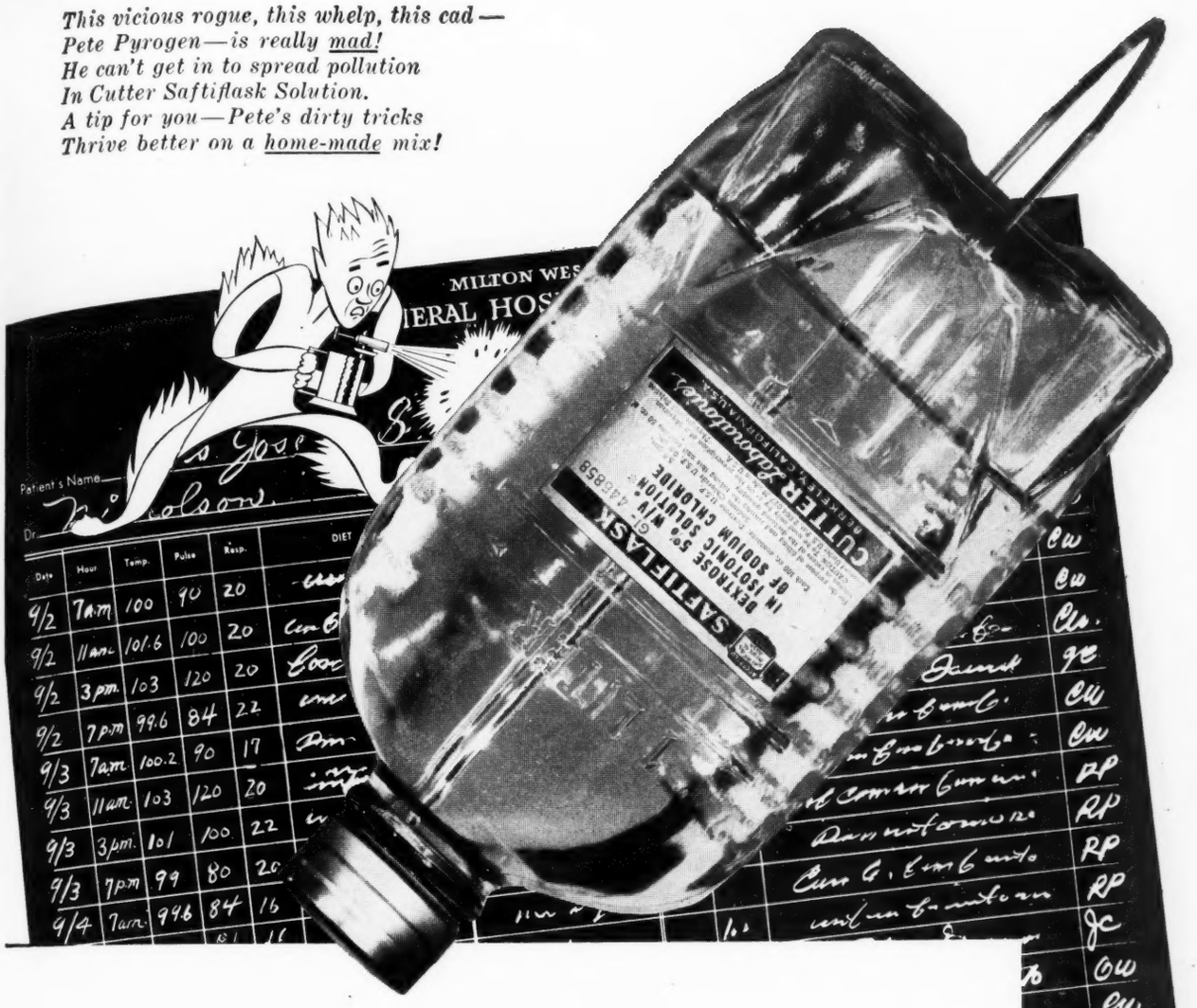

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From one VOLUNTEER to another

RAYMOND P. SLOAN

HOSPITALS need volunteers to a greater extent today even than during days of actual war. Appeals appearing in local newspapers all over the country testify to this fact. The reason is obvious. Many who valiantly came to the aid of our hospitals during what was termed the "critical" period have dropped out with the resumption of home ties. With some notable exceptions there has come a let-down in volunteer spirit which, while completely understandable, is still greatly to be deplored.

At the same time there has been no let-up in the demands for hospital service. Waiting lists for hospital beds still prevail, with new names added daily. The beds are there in many instances, but without hands to serve them and until such time as an adequate supply of nurses and other hospital personnel is available these beds must remain empty and individuals requiring medical and surgical care must be kept waiting.

Trustee Should Be Concerned

This sad state of affairs may or may not be news to the hospital trustee. It should be of concern to him, nevertheless, affecting as it does the service his institution is able to render the community and the good will it engenders among its constituency. Being a volunteer himself a trustee can more easily comprehend the layman's point of view and can more effectively interpret to him hospital needs. Consequently, his interest and cooperation are being sought in meeting an emergency which continues and which may be expected to continue for many months, or at least until the world seems nearer to peace than it does today.

They Feel Unwanted

It is possible that some volunteers have dropped by the wayside because they felt they were no longer needed. If so, whose fault is this? It is possible that others have permitted their interests to become diverted elsewhere because they felt that their contribution was not sufficiently appreciated. Without attempting to analyze the source of the difficulty, we might consider certain corrective measures now and the part that the trustee can play in them.

Whatever type of service they perform, volunteers respond to recognition. They like to feel that their efforts, however modest, are appreciated. Trustees themselves are not above such human reactions.

Therefore it would seem well worth the time, effort and expense involved to pay public acclaim to the war record of these public-spirited men and women, at the same time urging their continued cooperation and support. And it is logical that such tribute should come from the trustees who comprise the governing board of the institution.

There are various patterns for such a ceremony, some of which have already been enumerated on other occasions. Because it is still news, however, we might review briefly an inspiring sight that took place in the Cathedral of the Incarnation, Garden City, N. Y., on a recent Sunday afternoon when a special service was held in honor of the volunteers of the Nassau Hospital of Mineola.

Engraved invitations issued in the name of the board of directors were mailed well in advance, assuring an audience of some 1300 persons. From the Cathedral House, two blocks away, to the Cathedral marched 500 volunteers dressed in their respective uniforms. They were led by a color guard from neighboring Mitchell Field under the command of a lieutenant; also by the Nassau nurses, all in uniform.

Following an appropriate religious service, expressions on the value of volunteer effort were voiced by a member of the medical staff, the president of the board, a representative of the local chapter of the American Red Cross, a county representative and a nurse's aide. Each speaker was allowed five minutes only.

Asked Volunteers to Continue

Awards "for services so generously and capably performed which have aided substantially in the operation of the hospital during World War II," engraved with the name of the recipient and bearing the signature of the president of the board of directors, were made by George L. Davis, executive director of the hospital. In distributing these to a representative of each group, who in turn distributed them to the individual members, Mr. Davis expressed the hope that the volunteer service would continue until the hospital was again completely staffed.

The response to this event was most enthusiastic. According to latest reports it has done much to promote continued interest in hospital work

on the part of the volunteers. Certainly, it was a fitting tribute to volunteer support.

A similar gesture was made by the board of directors of another institution in the form of a page in the local newspaper which expressed the board's appreciation to the volunteer group, listing them by name. Others have staged rallies at which awards and special recognition have been distributed. Yet, by and large, these men and women have come and gone with little planning as to how their support might be sustained as a protection to hospital service in the immediate and still uncertain future.

Let's Tell the Story

The voice of the trustee, speaking as from one volunteer to another, will help more than anything to maintain this support which is so essential. Quite aside from the desirability of honoring the volunteer for past performances, there is need to assure each individual that the fight is not yet over and, further, that there will always be need for hospital volunteer service of one type or another.

This voice should be heard before local Rotary, Kiwanis and other civic and fraternal groups. The church member can accomplish much in describing hospital needs on suitable occasions. The club member can make it the subject for discussion at formal round tables to which the public is invited or in smaller groups gathered informally. The journalist or newspaper man can write about it. The educator can tell of it to his student body. Every board member, whatever his business or profession, can contribute his share to rallying volunteer support about the hospital.

The subject is of sufficient importance to warrant careful consideration at the next board meeting—at every board meeting, in fact. What is the situation today as it affects volunteers? To what extent has volunteer service declined since the end of the war? Among what groups is this most noticeable—nurse's aides, dietitian's aides, motor corps members, administrative staff assistants, male attendants? What are the hospital's needs and, barring the possibility of employing paid labor, what steps can be taken to obtain additional volunteer assistance?

The paid director of volunteers, provided there is one, should be asked to present her report in person before the trustees and get the benefit of their thinking. Otherwise, the head of the volunteer group or auxiliary, if she is not a board member, should be privileged to sit in at board meetings when volunteer activities are discussed.

All this is recommended not only to meet the present grave situation but to provide for future planning. Hospitals, as a result of the war emergency, have enrolled enthusiastic armies of men and women who have labored valiantly in their behalf. Are these to be permitted to disperse completely or will they be held in reserve for other tasks which, as laymen, they can perform even better, perhaps, than can professional workers? For no one can deny what volunteer spirit has done for patients and institutions alike.

The difficulty is that little study has been given thus far to volunteer functions in the future for the reason that everyone has been too busy enrolling, training and directing volunteer effort during the emergency. Yet action in this direction cannot be too long delayed; otherwise, the time and energy of our friends will have become wholly diverted to other interests.

What we must work for and what is quite essential to voluntary hospital support is the maintenance in peace time of a standing army of volunteer workers just as loyal as they proved themselves in days of war. The test will come in one year or two. Shall we witness further presentations of awards for volunteer effort that will read "for services so generously and capably performed which have added substantially in the operation of the hospital in the difficult period *following* World War II"?

Let us hope so, also that such certificates of awards will bear the signature of the president of the board of directors—from one volunteer to another.

Question of the Month

Each month in this column one question bearing upon hospital trusteeship is presented and answered. The editor is glad to receive questions which any hospital trustee may submit. All identification will be withheld. Replies will be made by mail pending their publication.

QUESTION: What efforts have been made to bring together hospital trustees in one region for discussion of mutual problems, also to extend their knowledge of modern hospital practice? We are thinking in terms of three or four informal meetings a year to which the trustees of all local hospitals would be invited.—L.S.M.

ANSWER: There is unquestionably great need for such thinking and planning and it is to be hoped that you will carry through on your proposed effort. What has been accomplished thus far has been principally through so-called hospital councils organized to serve the two-fold purpose: first, to promote better community health service and relationships and, second, to improve internal administration.

In addition to including representatives from the boards of directors, such groups comprise representatives of the medical and nursing profession and the community chest and other social agencies. Complete information on the subject of hospital councils is available in a bulletin entitled "Organization of Local Hospital Groups" prepared by the American Hospital Association.

Attention also should be directed to the project successfully carried on by the Maine Hospital Association through the effort of its president, Dr. Frederick T. Hill of Waterville, in holding regional meetings for hospital trustees. These have accomplished much in developing greater comprehension of hospital problems, particularly among the little group governing small hospitals in that state.

Unfortunately, such improvements still embrace but a minority of hospital trustees. Board members generally need the stimulus of closer contact with other hospital workers and a greater knowledge of help and hospital needs which can be acquired only through an interchange of thoughts and ideas.

Another contribution to modern medicine is the Physiologic Laboratory

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WITH the growth of modern medical knowledge the hospital has evolved from an asylum for the care of the sick to an institution in which an increasing effort is devoted to furnishing the facilities for the various technics that are so important in the diagnosis and cure of disease.

The patient in the hospital today not only expects to receive food and nursing care but also expects to avail himself of the contributions of medical progress. To receive the benefits of modern medical science, it is necessary to have available certain fairly complex laboratory procedures which can be applied to the patient only while he is under institutional care.

Third Laboratory Is Important

The growing importance of the chemical and pathological laboratories in diagnosis and treatment are now generally recognized. However, there is a third contribution of modern medicine which is more recent in its development but which will ultimately play as important a rôle in the modern hospital as do the chemical and pathologic laboratories. For the lack of a more descriptive term this branch of laboratory science may be designated as the "physiologic or research division" of the modern hospital.

The physiologic laboratory in a modern hospital should serve to make available to the patient those diagnostic procedures that utilize specialized technics in experimental medicine comparable to the chemical, pathologic and bacteriologic procedures that are utilized at present.

It should be directed by a trained physiologist who would supervise the special technics of more recent development, as well as such procedures as electrocardiography and the basal metabolic rates that are already of general use. The latter are, unfortunately, in many instances so poorly supervised as to fail to give the reliable data expected of them.

The physiologic laboratory, moreover, would make available to the physician in his diagnostic studies the host of specialized physiologic and pharmacologic methods for which at present no facilities usually are available in the general hospital. For example, some of the highly specialized endocrinologic tests can be of inestimable value in diagnosis if facilities are available for their accurate performance.

Other special technics are available for the study of the circulation, the nervous system and other systems of the body. In short, all of the many physiologic and pharmacologic technics which have aided so much in the development of modern medicine could be used by the physician for the better care of the patient.

It must be admitted that, at present, only a few hospitals with large research departments can be said to avail themselves of the physiologic technics discussed in the preceding paragraph. Even in many of these hospitals, however, these activities are looked upon as primarily intended for the research activities of the workers in these laboratories rather than for the routine application to the patient. Ultimately, however, the modern hospital will be expected to maintain these facilities for the patient.

In introducing any new addition to a hospital the question immediately arises as to how much additional space and personnel will be required. As regards the latter, the fact is being more and more appreciated that to give the best service to the patient and to the physician practicing in the hospital, the attending physician should be in contact with the advances in research medicine, although his own contributions to research may be minimal.

The advantage of association of a hospital with a teaching institution is largely due to this contact, for only in this way can the physician be apprised of and appreciate the contributions which are being made by others and only thus can he, in turn, make them available to the patient.

The research activities of the attending physician in the modern hospital should be centered around the physiologic laboratory. Hence, the latter should be directed by an individual who not only is capable of supervising the technical work of the laboratory but is himself actively engaged in experimental medicine and hence will be capable of guiding the attending physician in his own problems. The physiologic laboratory would thus serve as the research center for the hospital.

Type of Facilities Needed

As regards its physical requirements, the physiologic laboratory should contain essentially the same facilities on a miniature scale that one finds in any modern physiologic laboratory. These should consist of a small animal room connected with a small experimental operating room; a large general laboratory in which most of the experimental work is carried out, including a chemical bench at one end, with the rest of the laboratory arranged for general

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physiologic experimentation, and a room to which patients can be brought and in which procedures that cannot be carried out at the bedside may be performed.

The cost of adding a physiologic division to the hospital will obviously vary with the size of the hospital and the extent to which its personnel takes part in research activities. The annual budget of an active physiologic laboratory would vary from $8000 to $30,000, depending on the caliber of its personnel. This expenditure, however, would greatly enhance the value of the hospital not only to its patients but to the physicians who utilize the hospital and also to the public generally, which would profit from the research accomplishments of the institution.

The Value of Manufacturing

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THE subject of the value of manufacturing in a hospital pharmacy may be sectioned into several subtitles but the scope of this paper shall be to consider the topic chiefly from three angles, *i.e.* the value that accrues to the pharmacist himself, to his profession in general and to the hospital he serves.

The pharmacist who does much manufacturing derives satisfaction from its accomplishment, a gratification which can scarcely be had from any other of his duties. Psychologists tell us that the creative instinct is fundamental in man; that his happiness depends largely upon his ability to view his own handiwork with pleasure.

After bottling several gallons of a sparkling solution, after clamping a set of ointment tubes or after packaging a set of immaculate ampules, who of us has not experienced the contentment and renewed self-confidence that go with a job well done.

Increases His Prestige

The hospital pharmacist increases his own prestige through the medium of his ability as a manufacturer. Social and business relations in a hospital are much like those of a small town—everyone has a pretty clear idea of what the other fellow is doing in his department and soon comes for professional and personal advice to the pharmacist who is daily displaying his training and his mastery of the pharmaceutical arts.

Doctors and interns appreciate the fact that the official preparations they prescribe are being freshly prepared by an expert manufacturer, while nurses are more interested in watching the preparation of cold creams and vanishing creams. The latter is, incidentally, often a happy and instructive disillusionment to the nurse who beholds the simple and inexpensive ingredients that go into the making of these cosmetics for which she has been paying high prices.

Doubtless the greatest benefit the pharmacist can obtain from his manufacturing is a continued love for his work. So long as the pharmacist does his own manufacturing, he will remain interested in his daily tasks, and as long as he is interested an esteem for his work will naturally follow. The gravest error any professionally minded pharmacist can commit is to relegate his manufacturing to commercial houses provided, of course, he has the time and facilities for doing it himself.

The next question is the importance of the manufacturing pharmacist to his profession. During the past several years, leaders in pharmacy have been concentrating on means to recover professionalism and regain prestige. Hundreds of professional pharmacies have appeared throughout the country; some of these are professional in name only, while others are streamlined prototypes of European apothecaries. One cannot deny that those who operate professional pharmacies are doing much good for the profession.

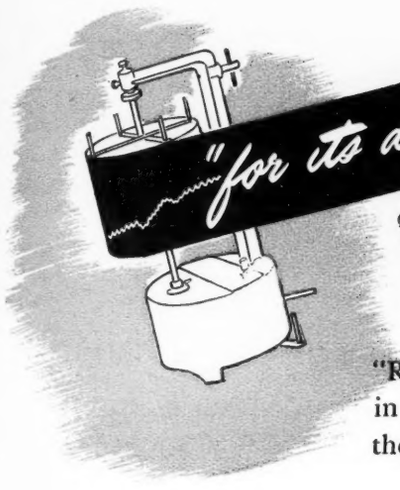
Along with this renovation, hospital pharmacy has been subjected to scrutiny, with the interesting discovery that probably the most professional of all pharmacists are those in the group of approximately 5000 who are employed in hospitals. And this is not surprising. Eye specialists know how to refract eyes and so do general practitioners, yet when we need to have our eyes tested we do not consider the latter but go to the specialist. We have confidence in his ability because we know that he does nothing else from morning till night except test eyes, and it is this constant repetition that lends him skill.

For years, hospital pharmacists have handled drugs and talked drugs from morning until night. If they do have a sideline, it is usually associated with an allied profession, such as x-ray or laboratory work. What seems really surprising is that this group was not recognized long ago.

Can't Cure All Ills

I do not presume to say that hospital pharmacists can cure the ills of the profession by means of manufacturing, but it is true that through it they have many golden opportunities to better conditions. For example, let us consider the matter of proprietary preparations. The average retail druggist fills prescriptions for four or five physicians and therefore stocks about the same number of proprietary cough syrups which are popular with the physicians who patronize him. The same condition prevails in all the drugstores in that city, and practically every proprietary cough syrup is to be found in one or another of the stores.

In the hospital pharmacy, however, prescriptions may be received from any or all of these physicians and therefore all brands must be kept on hand. What is said of cough syrups applies also to digestants, hypnotics and practically all drugs.



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Johnson, C.A.: Surg. Gynec. & Obst. 65:458, 1937.

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**Kelly, M.: Anesth. & Analg. 19:107, 1940.*

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†Rochberg, S.: Anesth. & Analg. 22:174, 1043

Thus, this duplication becomes a major problem of economics. But the pharmacist, provided he has the confidence of the staff and provided he has kept up to date through his manufacturing, can often make valuable suggestions for suitable prescription combinations and can direct the doctors toward the use of official preparations.

Likewise, most hospital pharmacists find that interns are eager for information and professional suggestions given them may remain with them during their subsequent practice. Each doctor who is converted to official preparations helps, through this, to raise the standards of pharmacy.

Last, we shall consider the importance of manufacturing to the hospital. From the returns of a questionnaire sent recently to a number of hospitals, it is interesting to note the large number of superintendents who rate economy as one of the principal problems confronting the pharmacist. The pharmacy should and can be one of the best investments in the hospital; any alert pharmacist can prove this to his superintendent. And here it is that manufacturing is his biggest asset.

Many commercial houses grant discounts to hospitals and the pharmacist should take advantage of these when possible. Chemical firms, for example, frequently make concessions for large orders and if the pharmacist plans wisely he can often realize a considerable saving for his hospital.

The pharmacist must be guided by prudence and a knowledge of his own ability in selecting the preparations he wishes to manufacture but, ordinarily, he should certainly be able to prepare any official formula that does not require elaborate technic or assay.

Clinic Saves Life and Limb

KARL HARPUDER, M.D.

Attending Physician, Department of Physical Medicine
Montefiore Hospital, New York City

PERIPHERAL vascular diseases are diseases of the blood vessels of the limbs—arteries or veins or both. The blood supply to the limbs in these diseases is interfered with; pain, inflammatory reactions and trophic disturbances appear and result in ulcers, gangrene and, possibly, in amputations and chronic invalidism. The basis is the physical obstruction of arteries and veins, or a neurogenic vasoconstriction.

Peripheral vascular diseases are frequently the clinically prominent part of a systemic disease like arteriosclerosis. Or they are favored by systemic diseases, like diabetes or a sensitivity to tobacco, which is characteristic of thrombo-angiitis obliterans. Reynaud's syndrome and scleroderma, as well as other vasoneuroses, may appear as psychosomatic manifestations on a neurotic background. Moreover, vascular disturbances may be entirely local and the result of trauma, *e.g.* a frostbite, a fracture or a sprain, as in causalgia.

These few words will suffice to emphasize the complexity of the problems in peripheral vascular diseases. The social importance of these diseases is great because they lead frequently to chronic invalidism of the middle aged and sometimes of the young adult. It will undoubtedly increase with the return of our armed forces. Exposure to cold, immersion, trauma, excessive smoking, emotional strain, hypoxemia are common in the soldier's life.

Although the study of peripheral vascular diseases and their treatment has been intensively carried out for several decades in certain medical circles, the profession as a whole has shown a rather limited interest in them. The lay population is still uninformed on the subject of vascular problems, vascular hygiene and prevention of manifest disease, and entertains instead some horror complexes on "hardening of the arteries" and gangrene.

It is an obvious obligation of those experienced in vascular disease to continue and intensify their investigation of clinical and experimental problems; to spread the knowledge of diagnosis and treatment throughout the medical profession; to further the diagnosis and treatment of the individual case, and to instruct the lay public in prophylactic and hygienic measures. It is also an obvious obligation of large hospitals to provide the clinical facilities for a successful pursuit of such plans.

A readily available method is the organization of a special out-patient clinic for peripheral vascular diseases. Although special clinics for vascular diseases have been working in some hospitals for years, the project as developed at Montefiore Hospital, New York City, merits discussion for its broad organization and the cooperative utilization of the various facilities of a large hospital for such a clinic.

Our clinic is a medical clinic and therefore under the supervision of our full-time chief of the medical division. In direct charge is the attending physician of the department of physical medicine, who has interested himself for many years in the diagnosis and conservative treatment of peripheral vascular disease and in research along these and similar lines. The technical equipment of the department of physical medicine is at the disposal of this clinic.

The staff consists of members of the medical division and the surgeon in charge of the peripheral vascular service of the hospital, an outstanding specialist in the field, who acts as surgical consultant. Upon request, the division of neuropsychiatry, the orthopedic and dermatologic services and the podiatry service send members of their staffs to the clinic for consultation.

Moreover, patients can be referred to other clinics for prompt consultation or care or to the admitting office for admission to the hospital on the medical or surgical wards. Laboratory investigations on these patients are carried out in the laboratories of the medical division.

The peripheral vascular disease clinic is fully equipped for research work. It has at its disposal a blood-flow meter, a plethysmograph and a galvanometer with thermocouples for skin and muscle temperature. This equipment is located in the laboratories of the medical division. All of the facilities of these laboratories are available to the staff of this clinic.

Under these circumstances the clinic is in a position to give the pa-

tient complete care, to serve as a teaching unit for a large number of physicians and to participate successfully in research in peripheral vascular disease. Moreover it is in a position to apply the tenets of preventive medicine in this fertile field, on the cardiovascular and surgical services of the hospital among various others.

The vascular clinic saves limbs, prolongs life and makes our patients more comfortable. We therefore recommend it as a worthy demonstration project.

Mixtures Containing Acetanilid

A. J. LEHMAN

Department of Pharmacology, University of North Carolina

ACETANILID and its congeners, acetophenetidin, aminopyrine and antipyrine, belong to the potent group of pharmacologic agents known as coal-tar derivatives. The four drugs are official in the "United States Pharmacopoeia" as pure substances. Several preparations are recognized in the "National Formulary" and other combinations appear in "New and Nonofficial Remedies" and in "Accepted Dental Remedies."

The various combinations described in these four texts place in the hands of the professions a sufficient number of products to meet all requirements. However, exploitation of preparations containing acetanilid, often propagandized as new discoveries, has added many more to the list. The total number has been estimated at from 100 to 200.

Many of these proprietaries, or perhaps more correctly nostrums, contain in addition to a coal-tar derivative potent alkaloids like strychnine, caffeine, codeine and quinine, as well as powerful laxative resins, saline cathartics and salicylates. These are exploited as headache, pain and cold cures and appear in the form of pills, tablets, powders and effervescing preparations and lend themselves readily to over-the-counter sale or as a fizzing dose at cigar counters, bars, soda fountains and grocery stores. This indiscriminate use of coal-tar agents is a danger which has long been recognized by the medical and dental professions.

Acute *vs.* Chronic Poisoning. Since the nostrums are used as household remedies and are taken over a period of years, acute poisoning is relatively uncommon. Occasionally children may be acutely poisoned from the medicinal misuse of the drugs. In larger cities suicide may be attempted by ingesting a large number of headache powders or tablets. By and large, the laity has amassed certain knowledge regarding the limitations of the nostrum and the problem therefore resolves itself into a consideration of the effects of frequent and continued drugging rather than one of violent poisoning.

Chronic Poisoning. The symptoms and signs of chronic poisoning are sometimes extremely difficult to determine because they are nonspecific and may be produced by substances other than coal-tar products. In general, there are gastrointestinal disturbances which result in anorexia, reduced food intake, weight loss and impaired nutrition. Subjectively, there exist nervous irritability, lassitude, mental dullness and

muscular and joint pains and aches. The more specific effects are referable to blood dyscrasia and injuries to important viscera.

Cyanosis resulting from alteration of the blood pigment to sulfhemoglobin and methemoglobin is not uncommon. The reduction in the oxygen carrying capacity of the blood brings about dizziness, weakness, dyspnea, subnormal temperature and coldness of the extremities.

Icterus and albuminuria indicate liver and kidney damage and depression of the heart and vascular system. This, coupled with the anoxemia, produces cardiac irregularities and vascular collapse which may progress into shock. Of special interest are the respiratory pigment changes.

Methemoglobinemia and Sulfhemoglobinemia. The pigmentary changes have been the subject of considerable study. Acetanilid is relatively poor in its ability to produce methemoglobin. This pigment is not produced when acetanilid is added to blood *in vitro*. Certain conditions, among them a high acidity up to pH 5, must exist before this change can be accomplished. *In vivo* the conditions may be more favorable, such as a high carbon dioxide content of the blood, changes in red cell permeability and hemolysis which enhance the transformation of hemoglobin to methemoglobin.

Failure to consider these factors has led to confusing reports as to the exact mechanism involved. It has been pointed out that intermediate derivatives of acetanilid may be responsible for the pigmentary changes, namely acetylphenylhydroxylamine and paraaminophenol. Contact of acetanilid with tissues does produce these derivatives. Others claim that acetanilid is broken down to its original components, acetic acid and aniline.

To add to the confusion, it is known that the coal-tar derivatives, especially antipyrine, raise the blood sugar, and it has been shown that hyperglycemia favors conversion of methemoglobin to hemoglobin. In general, the conditions are such as to promote and prevent the formation of methemoglobin at one and the same time.

The other pigmentary change, that of hemoglobin to sulfhemogloben, has been demonstrated clinically and experimentally as arising from acetophenetidin. The data incriminating acetanilid are not as convincing as are those for acetophenetidin, but sulfhemoglobin formation is certainly favored by certain dietary conditions and gastrointestinal disturbances, including constipation and diarrhea.

Habituation. Habituation to acetanilid-containing nostrums has been firmly established. Usually the physician's advice is sought by an addicted individual when mental and physical health begins to deteriorate. Diagnosis of such cases is difficult because the decline in health as manifested by gastrointestinal upsets, malaise, weight loss, palpitation and dyspnea may be produced by a number of conditions.

Connection between these symptoms and the ingestion of a drug is not always easy and frequently positive confirmation of acetanilid habituation can be assured only if the patient admits of taking such nostrums. Even this presents difficulties. The advertising propaganda rarely reveals the ingredients of the nostrum and unless the physician has fortified himself with a fairly complete knowledge concerning the trade-marked and proprietary products there is small chance of demonstrating a direct relationship between symptoms and an offending drug.

Withdrawal symptoms of acetanilid habituation have been reported both in man and in experimental animals. Abrupt withdrawal has produced mental derangement bordering on mania which could be controlled by small doses of acetanilid but not with other depressants, such as barbital and morphine. (*Continued on Page* 110.)

Fatal and Tolerated Doses. Fatal acetanilid poisoning is as insidious as chronic poisoning. The acutely fatal dose in man has been listed as from 2.1 grams to 49 grams when taken at once. However, if cardiovascular disease exists, the individual is extremely vulnerable and the killing total dose of these drugs drops to from 1.4 grams to 0.6 gram.

The habit of the makers of the nostrums to report the safety of their preparations as based on animal experimentation is misleading. Man is notoriously more sensitive to acetanilid than are lower animals.

Fatal doses as determined in rodents cannot be transferred to man. Rats and rabbits are highly tolerant to coal-tar poisoning which is due partially to species difference and particularly to the resistance of the herbivera to methemoglobin formation. Such data contribute little or nothing to the solution of the problem of fatal poisoning in man.

The tolerated dose in man, that is, the quantity recommended for maximum therapeutic effect, is extremely variable but is of the order of 1.0 gram total daily. This amount represents only about 1/25 the tolerated doses as determined in several species of animals. Again, the transference of such values to man is entirely fallacious and misleading.

In conclusion, the use of coal-tar derivatives is not without danger and if the drugs could be limited for use on the prescription of a physician or dentist, there would be no need for repeated warnings against the exploitation of these agents to the public. Commercialized propaganda has placed the drugs in millions of homes and has created the problem of mass medication with potentially harmful agents.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Penicillin for Appendicitis

Will chemotherapeutic agents replace surgical procedures?

This question is of prime importance not only to the patient but to the surgeon.

Certainly, no patient would select an operation in preference to an infusion. These are the thoughts raised by George Crile Jr. in his paper, "Appendicitis, With Emphasis on the Use of Penicillin," which appears in the *U. S. Naval Medical Bulletin* **45**:464-473 [March] 1945. Carbuncles and empyemas are treated with penicillin, it is reported.

Will this drug replace the knife in cases of acute appendicitis? Doctor Crile seems to favor this view for he states that, "an appendectomy is designed not to treat appendicitis but to prevent peritonitis." His contention is sustained by records of appendectomies performed in the enlisted personnel at the U. S. Naval Hospital, San Diego, Calif. During a period of eighteen months, 1500 operations were done, with one death. No deaths occurred among patients with unoperated cases of appendicitis.

Penicillin (100M units) injected intramuscularly every two hours has a definite effect in controlling peritonitis. It plays the important rôle in appendicitis infections and thus removes the danger of surgery and its sequelae. Appendicitis itself is a self-limited disease and subsides completely in forty-eight hours. The author realizes that the low mortality rate involved many factors.

The vital question for the Navy is whether, in view of the efficacy of treatments with large doses of penicillin, the risk of appendectomy at sea on small ships is not greater than that of conservative chemotherapy.—MICHAEL LEVINE.

FOOD SERVICE

Columbia's Kitchens

Testimonial to Thoughtful Planning

MILDRED WHITCOMB

COLUMBIA Hospital, Milwaukee, is not growing rankly like a weed but scientifically like a tested, selected, tended plant. Its development is directed by a progressive board of trustees and medical staff, competent advisers, including architects, talented women of the community and many others. Joseph G. Norby is the administrator.

Columbia's kitchens, once in the geographical center of the physical plant, seemed suddenly to find themselves in a new and inconvenient location in an expanded layout comprising 150 beds. Food had to be transported to floor kitchens so remote from the newer patients' quarters as to reduce its palatability. Now a well person does not relish his hot foods cold or his cold foods warm; as for the sick they are notoriously finicky about every aspect of diet.

So it came about that, war shortages or no war shortages, a newly located kitchen unit was deemed essential. Without going into the long distance telephoning, the delays and disappointments, the square-jawed determination that preceded the final triumph, this observer can now state that Columbia's most recently completed construction, a kitchen addition, is amazingly complete, efficient and enviably handsome.

Moreover, this kitchen unit must be a genuine joy to work in, for one rarely comes upon a prouder, happier crew of food handlers than this, from Chief Dietitian Helene Henley down to Albie, keeper of the storeroom keys; Rosie, the directing genius of the dishwashing room, and Frank, who swishes the debris off the dishes by means of a patented soaking device with the fine flourish and fervor of a Toscanini.

With the first prospect of new kitchens, the serious business of planning and replanning began; the results are revolutionary so far as Columbia's food service is concerned.

It was decided, first of all, to abandon floor kitchens and to install centralized food service. It was decided, second, to install both a horizontal and vertical transport system to carry trays to newly and centrally located floor serving stations. It was decided, finally, to inaugurate a cafeteria system to supersede the waning waitress service offered staff and employes.

KITCHENS AND CAFETERIA

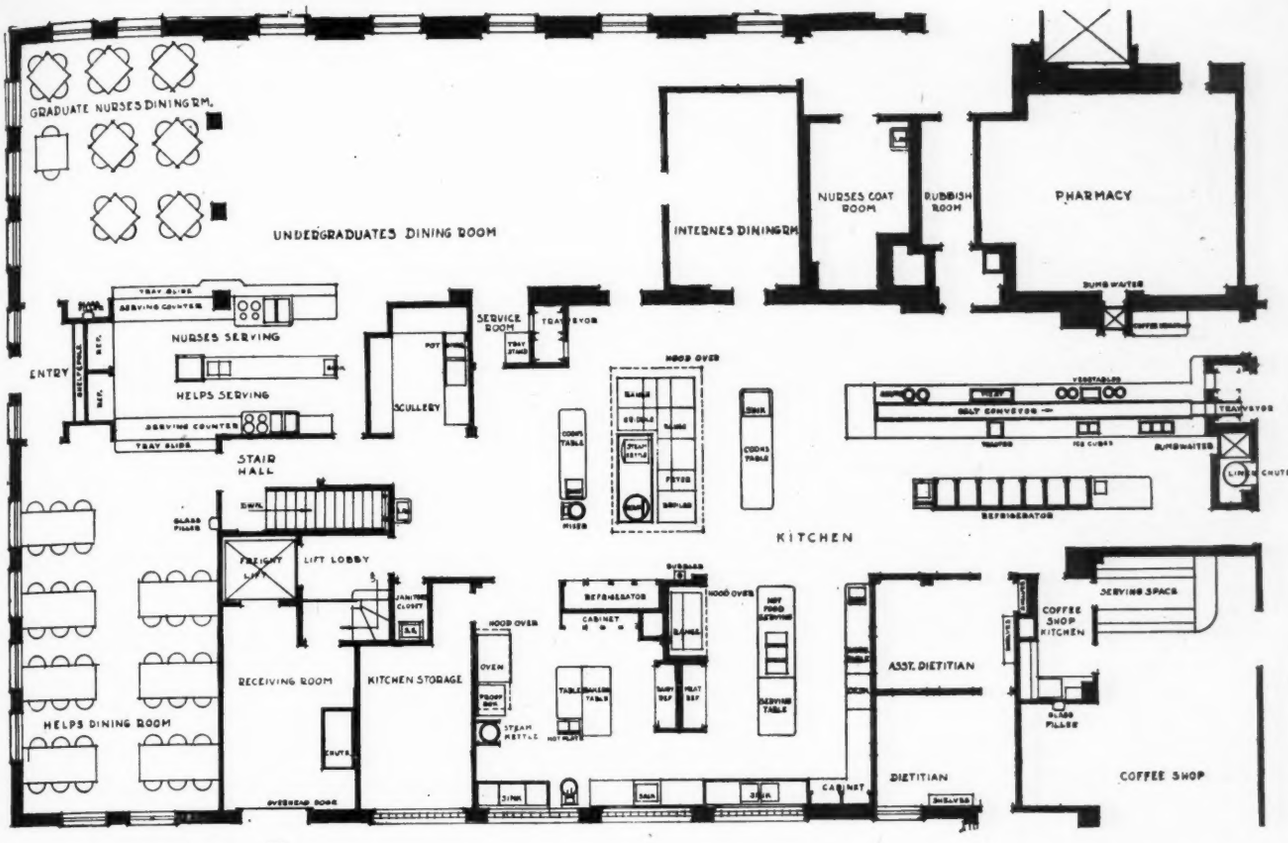
The new kitchen unit sprouts midway off the hospital's main stem, which connects the old and new sections. It is a one story and basement structure. The former kitchen area near the street is now being converted into sorely needed out-patient and central service departments.

Eschweiler & Eschweiler, Milwaukee architects, designed the addition, floor plans of which are shown. Areas are logically arranged for supervision, preparation and service. The pots and pans washing area is partitioned off from sight and the same recess conceals the necessary but hardly esthetic garbage cans.

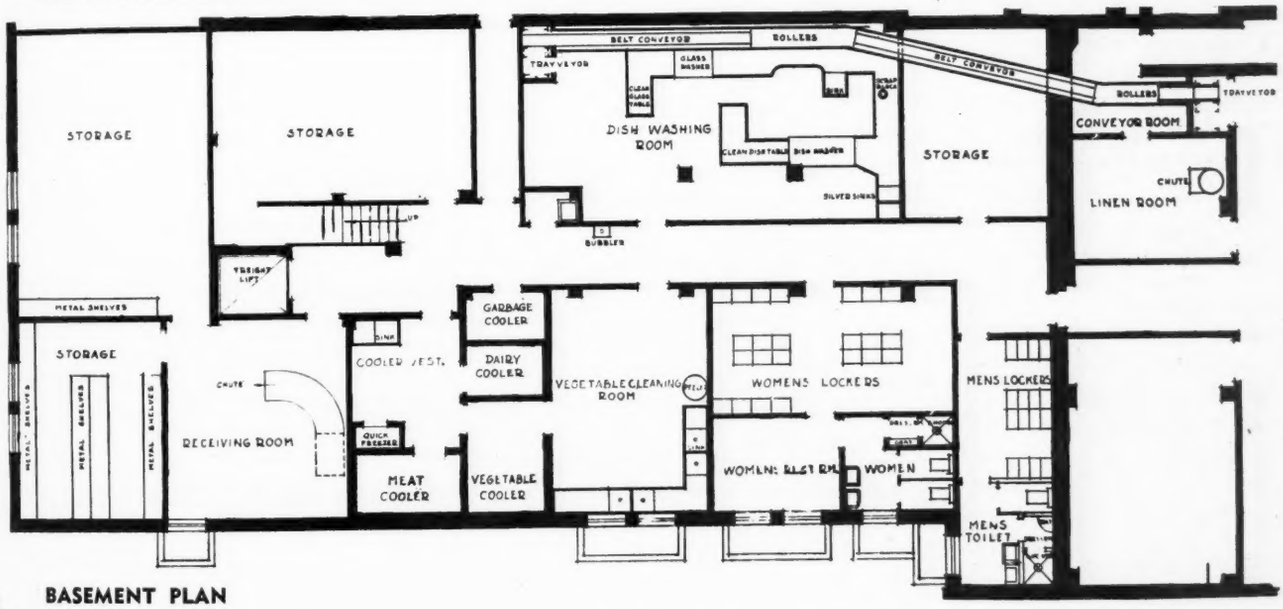
Kitchen floors are of red quarry tile; interior walls and partitions of salt glazed tile, light cream colored. Ceilings are acoustically corrected with a product that is not affected by steam and that can be repeatedly washed and painted without loss of sound-absorptive properties. Natural lighting is from glass block areas on the diet kitchen side and from windows of the conventional type in the cafeterias.

Fresh modified air is brought into the new addition by unit ventilators,

The conveyor belt crew is lined up and ready to start at Katy's signal.



FIRST FLOOR PLAN



BASEMENT PLAN

and a powerful central exhaust system carries all odors away from the building. In cold weather these unit ventilators warm the air; in summer a refrigeration system cools it.

Equipment, including work tables, refrigerators, counters and sinks, is of laminated stainless steel and is maintained close to its original sheen by prideful employes. A favorite item in the pastry cook's area is the new mounted pudding cooker, with a manually controlled tilting device, which, when puddings and pie fillings are ready, permits the contents to flow over a generous lip into the proper containers.

Few commercial cafeterias can duplicate the smart metropolitan air of the new dining rooms given over to the professional and nonprofessional staffs. The hospital's house committee, assisted by a Chicago firm of decorators, William J. Quigley, Inc., planned wall and window treatment and these are most fetching. Above a painted cream wood wainscot the walls are papered with an imported paper in a striking design called "Monuments of Paris." The all-over pattern is in soft red on a light cream ground. The paper has been sprayed with three coats of colorless lacquer, a process that makes the walls washable.

At the many windows hang shades of a wood-web material, bordered with a small patterned chintz of red figures on a cream ground. These unique shades operate on an ordinary wood roller and are substantial; the woven wood softens the light and

Professional decorators planned the attractive dining rooms for professional and nonprofessional employes. Imported wall paper, cream colored wainscot and wood-web shades contribute to a delightful environment.

breaks it into satisfying patterns. Such a window treatment gives the light control of a heavy linen shade and some of the decorative effect of tailored draperies and is less of a maintenance problem than are venetian blinds.

Tables and chairs are of simple design, the tables having red composition tops that require no linen. The floor covering is a grease-resistant asphalt tile in two-toned squares.

A temporary flaw in the cafeteria is the lack of acoustical treatment; this will come at the ceiling level later as the type desired becomes available.

One end of the professional staff dining area is partitioned off for the use of the medical staff; the partitions are partly glazed for borrowed light.

What delights Mr. Norby is that the choice area in the cafeteria is the sunny room, partly cut off from the main dining room by the serving counter, that is allotted to nonprofessional employes. Here without feeling conspicuous the engineers, painters, dishwashers and kitchen help can eat in their work uniforms. But as they eat the identical menu served the professional staff they look out upon green grounds and in upon the same lovely walls, window and floor treatment that the nurses, doctors, office workers and dietitians enjoy.

While the workers at manual tasks relax at mealtime on the ground floor, a certain number of them soon return to that beehive of activity, the basement. Let's go below stairs for a quick look-see, pausing for an interested glance at the great delivery chute where cartons of supplies from the service entrance swish down to Albie's neat storerooms.

Besides these locked storerooms we find the central refrigeration system; walk-in coolers for meats, frozen foods and fresh produce; a vegetable preparation room with its sinks for washing lettuce and spinach; the dishwashing room, where Rosie and Frank and their crew go into action, and lockers for men and women workers.

All the messy, noisy work goes on in the basement away from the business of food preparation above. For example, used dishes on the trays come down from the floor serving stations by conveyor belt to the dishwashing room, where they are scraped, washed, sterilized and returned to the kitchen by the conveyor system.

FOOD SERVICE

The goal of the modernized food service at Columbia Hospital is to have the entire control of food, from purchase through planning of menus, preparation, transportation and distribution to the bedside, the sole responsibility of the dietary department. Assistance will be asked of other departments only in emergencies.

This all-dietetic control obtains at present only up to the final step, distribution of patients' trays on the floor. With the employment situation easing, Miss Henley expects soon to be able to hire teams of tray passers of poise and suitable appearance who can relieve the nurses of the interruptions to service that come at mealtimes. The tray passers will also be tray collectors and will have other duties assigned them.

When this not distant day arrives, the system will have been cleared through the nursing department so that nurses or attendants, preceding the tray passers on sharp schedule, will have the patients washed, the beds cranked to the correct angle and the bed tables ready to receive the trays of piping hot food.

Already much progress has been made in interdepartmental cooperation. When the change-over from decentralized service took place last July, it was initiated only after a series of carefully prepared conferences and communications.

Mr. Norby, the administrator, addressed the medical staff by means of a duplicated memorandum, asking the men to refrain from making rounds or visits during the designated meal periods. With this request there was prompt compliance, since with the new system of food transport the meal periods have been greatly shortened.

Meanwhile, a series of conferences began with Mr. Norby, Miss Henley and Miss Anderson, director of nursing service, in attendance, and an understanding of the problems involved on the nursing floors developed. As matters now stand the student nurses push tray carts from the floor serving stations to the rooms. Dietary department maids bring the trays back to the stations for dismantling. A nurse, however, can scarcely refuse to adjust a window shade or perform some small service at the patient's request when she delivers a tray and a few digressions make for cumulative delays in the delivery of succeeding trays.

GENERAL AND SPECIAL DIETS

Menus for those on the general diet are worked out by the chief dietitian and for any given day and are mimeographed twenty-four hours or more in advance by the office staff on a three-section perforated sheet of light cardboard. The top section, torn off first for use on the tray, contains the breakfast menu, with blanks for the patient's name

and room number and with ample space on either side of the menu for write-ins or notations. The other two sections contain the dinner and supper menus, with identical spaces for patient's name and room. These, too, find their way on the trays by a method later to be described.

Special diets are based on the general diet, and two alert therapeutic dietitians, Miss Tellich and Miss Shaughnessy, divide the house, visiting patients and keeping track of their special needs. Merely by crossing out the unallowed items on the general diet menu and by writing in with a No. 2 pencil at the side of the menu the special items required, the therapeutic dietitians have an easily read menu for the patient's tray as it passes down the assembly line.

In the event that some notable omission is to be made from the tray, such as for a salt-free diet, the special dietitian seizes her red pencil and writes a warning message across the top of the card: "No Salt." Diagonal red lines across the corners of a card denote that that patient's tray must come back unscraped to the diet kitchen and not travel disassembled to the dishwashing room in the basement, for this person's leftovers must be calculated owing to the nature of his disorder.

Changes in diets occurring after the therapeutic dietitian's daily check are collected from the floors half an hour before serving time by a runner. These changes in orders are made on a special form by the head nurse on each floor.

Dietetic control of every patient is maintained through a visible card index system. Being a child of thrift, Miss Henley takes the backs of the used menu cards and types the pertinent data on these; they fit exactly into the visible card index file. On each card will be found the name of the patient, room number, diet order, doctor in charge and all changes in orders.

Notices of new admissions come to the dietary department directly from the admitting desk but discharge notices come by way of the floor order slips previously mentioned.

TRANSPORT OF TRAYS

The assembly line technic takes sound organization, practice, alertness, manual dexterity and a certain quiet rhythm. Columbia's conveyor belt is manned at dinner and supper by a crew of nine; fewer persons are needed for the simpler breakfast menu.

A head girl, Katy, is responsible for the condition of the conveyor belt and its flanking serving counters for hot and cold foods. Katy sees that each worker is assigned to her post, trains them for that job, sees that they are ready to start on the minute.

Immediately behind the "cold side" of the belt is a bank of refrigerators, the final unit of which adjoins the special diet counter and accommodates the cold foods of the special diets. The special diet items have been prepared by two special order cooks and student nurses under the supervision of the therapeutic dietitians.

As the meal hour approaches some trays bearing the individual plates of salads are withdrawn from the refrigerators, an ice cream container is taken from its ultra-cold storage unit, the trays of butter pats and fruit juices are removed from their shelves.

On the opposite side of the belt, the automatic hot dish dispensers are ready to perform at the first lift of a plate, the steam table containers give forth an aroma of delicious food, the coffee urns are ready and at a signal the power is turned on the belt.

At the head of the line a white uniformed girl (all helpers wear white short-sleeved uniforms, white socks, white shoes and hair nets) lifts off the waiting pile a tray covered with a colored linen cloth and matching napkin, places on it like a forward mast the diet card for Room 201 in its silver holder, adds salt and pepper shakers and flat silver and slips the tray on the moving belt, where quick hands from either side place on it a hot plate of hot meat and potatoes, a cold plate of bread and butter, a hot serving of vegetables in a hot, hastily covered dish, a cold plate of salad, a cold dish of ice cream or pudding, a hot coffee pot and a hot cup and saucer.

Each helper watches that forward mast with its diet card as the tray sails along, modifies the set menu according to the penciled directions contained insofar as it applies to her item of service. In a twinkling the tray for Mrs. Anderson in Room 201 has almost reached the end of the horizontal line.

There where horizontal and vertical meet stands the therapeutic dietitian who is responsible for the second floor. She checks the completed contents with the menu, takes off an unwarranted item if a mistake has been made along the assembly line, calls for the runner to bring any missing item, slips a hot metal cover over the dinner plate, whisks off the toothpick-impaled slip on special diet offerings and allows Mrs. Anderson's tray to slide into the vertical section of the conveyor system where it mounts to the floor above. Meantime the trays for Rooms 202, 203, 204, 205 and so on drift down the line spaced at a distance of 1½ trays apart, for the Columbia Hospital speed at present is to load, check and dispatch six trays a minute. Top speed is eight trays a minute.

What's this we see? Here's a tray containing only an empty dinner plate and some extra flatware. Has somebody made a mistake?

Marks the "End of the Line"

No, this is the signal that the trays for the second floor have been completed and it is time to adjust the apparatus so that the next stop for trays will be the floor above. That extra plate tells the girl on the second floor receiving station that the last tray for her floor has arrived. And, if a mishap occurs in the serving, the extra plate and silverware may come in handy.

The belt is started running again but this time the tray for Mr. Black in Room 301 comes floating down the line. There has been a quick exchange of jobs at the end of the assembly line; now the second therapeutic dietitian is checking the trays for on this floor are her special diet patients. Her colleague now leaves the kitchen to supervise the passing of the trays just served on her floor. So the trays glide on again in calm and rarely interruped rhythm.

Now let's go upstairs where the vertical transport system is delivering those six trays a minute to the serving station. At the receiving window stands a girl who takes off each tray, makes a check mark opposite the room number on a printed list of room numbers, unoccupied rooms having been checked off earlier. She puts the first six trays in numerical order on a cart and a nurse is supposedly on hand to roll this cart down the corridor and

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deliver the trays to patients in Rooms 201 to 206. The second six trays go on another cart and are rolled off.

So it goes until the telltale tray with its bare plate and extra silver appears, at which time the tray receiver rechecks to see that the number of trays received actually completes her floor schedule, every room having its appropriate check mark.

If extra servings are requested, a telephone request to the kitchens will be answered by the runner or special order cook. The runner will collect the item and it is sent up, not by the automatic conveyor system but by an adjacent dumbwaiter.

Her job temporarily done, the tray receiver on the second floor, goes to the fourth floor to await the beginning of service there while a coworker is handling the third floor reception. All of Columbia's patients are housed on three floors.

The meal over, the trays are collected and delivered to the receiving stations by the maids. There each tray receiver strips the tray, putting salt and pepper shakers and diet card holders on separate trays and sends them down to the kitchens. She also separates glassware, silverware and coffee pots on various trays and sends them to the dishwashing room. The soiled dishes themselves are carried down by conveyor system to the dishwashing room on their original trays.

The tray receiver then checks to see that all trays have been returned, cleans up the serving station and reports down to the kitchens for further duties.

RESULTS

No great gain without some loss, so the saying goes. First, what are the gains?

A dietary department has as one of its principal functions the serving of nutritious, palatable food that will help restore the patient's health and speed his convalescence. Most hospitals serve nutritious food but whether or not it is palatable depends quite as much on the temperature at which it reaches the patient as on its preparation, appearance and flavor.

Columbia Hospital's centralized service has speeded the food service; when it attains its ultimate goal of complete control by the dietary department the food will reach the patient in the briefest time possible. For a hospital of its size, centralized service can be made to work admirably.

There have been some losses. The bill for electricity has risen somewhat. More labor is required. To complete the final step of employing tray passers will mean another advance in labor costs.

Is there anything to offset these losses, even though they might possibly be disregarded in consideration of improved patient service? The answer in today's slang is, "But def."

The nibbling and pilfering of food from the floor kitchens, under decentralized service, add up to shocking figures when considered in the total food bill. Just how much food can be saved in that way Columbia does not yet know. When those figures are available, they should be interesting.

All the administration and the dietary departments know at present is that they have no wish to return to decentralized service. For Columbia Hospital's new system has already proved itself.

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At last, you and your business have stepped into Uncle Sam's shoes. You and your long-neglected equipment needs supply our objective from now on. Only from you can we hope to win further awards for "Excellence of Production"—that other star we want.

Temporary Models? No!

In other words, every resource of the far-flung Hobart organization goes into the battle to get food machines to you quickly. Not stop-gap, temporary models, either. *Look for a standard line of scales, dish washers, peelers, slicers, choppers, mixers and coffee mills built to rigid Hobart standards* —familiar in every way except for battle-tested improvements. Look, too, for new Hobart-engineered products to be announced, for food machines with *new* uses that will give you the advantage of having *all* your equipment built, serviced and guaranteed by the world-wide Hobart organization.

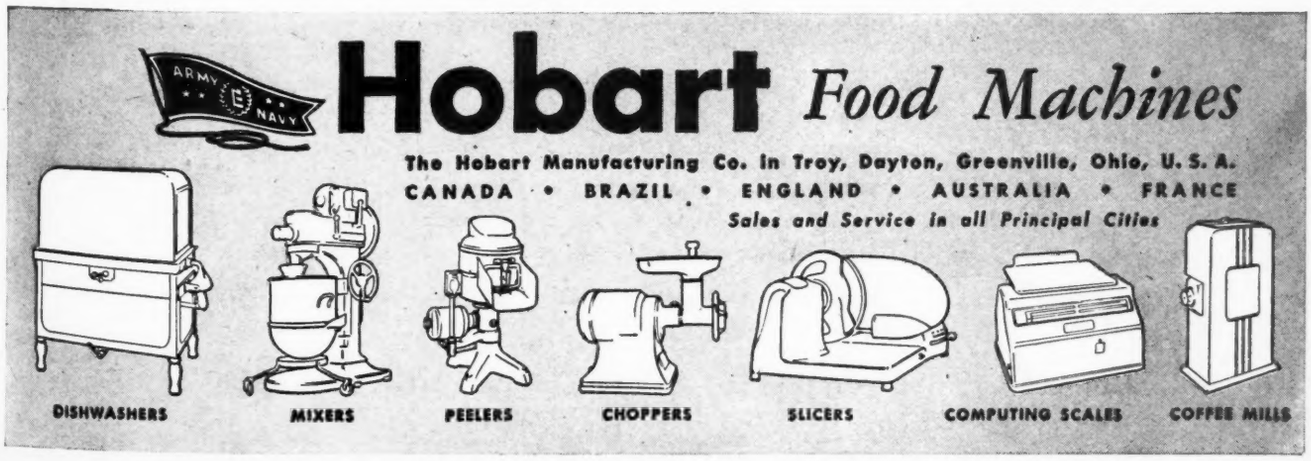
Deliveries — When ?

Typical models of our complete line are in production now. Others will come as soon as possible. Your Hobart representative will be glad to keep you up to date.

Order with Confidence

Those 4 stars that our flag bears so proudly were awarded in recognition of great responsibility capably met. They mean that *5 times*, Hobart was cited for "Excellence of Production"—more times than any other company in our industry. Proud as we are of that record, we regard it not only as a worthwhile goal accomplished but as an everlasting challenge . . .

A challenge to meet *your* needs as capably. Tell your Hobart agency or kitchen outfitter about them now. We will do our part.



Diet for the Tuberculous

A LOGICAL basis on which to estimate the cost of food for the tuberculous is the cost per patient per period of arrestment of the disease rather than the cost per patient day.

This is the opinion of Dr. Francis M. Pottenger Jr. of the Pottenger Sanatorium for Diseases of the Chest at Monrovia, Calif., who spoke before the Conference on the Control of Tuberculosis in a Metropolitan Area sponsored by the Chicago Academy of Medicine, November 13.

If a highly vital diet of slightly greater cost will restore the patient sooner than a cheaper diet, the end result will save the taxpayer a considerable amount of money.

Such a "highly vital diet" is used as a therapeutic agent at Pottenger Sanatorium and Doctor Pottenger thinks that it could be adapted for use by public institutions by using less expensive cuts of meat, whole grain cereals and breadstuffs and a reduced intake of carbohydrates.

About half of the patients at Pottenger Sanatorium elect this diet and have voluntarily returned to it after periods of change.

The four fundamental principles on which this diet is based are as follows:

1. An attempt to provide the vitamin requirements through foods naturally rich in these elements.
2. As little alteration as possible of food constituents by applying low pressures in cooking.
3. An extensive use of the hydrophilic collodial properties of gelatin.
4. An adequate supply of minerals obtained by using relatively crude food stuffs.

Roughly, the diet provides a daily intake of 225 grams of protein, 250 grams of fat and 235 grams of carbohydrate. On this diet the patients gain weight for about three months although they frequently diminish in actual measurements. They improve in tissue tone in spite of lack of exercise, thus avoiding the muscular fatigue suffered by tuberculous patients when they resume physical activity after long periods in bed.

The diet also helps correct the bowel habits of patients with long-standing constipation. Those with tuberculosis of the bowel begin to regulate their evacuation, and nocturnal diarrhea is lessened. The diet also apparently increases resistance, cutting down gastrointestinal complications.

Doctor Pottenger reports that he has seen a positive tuberculin reaction in children disappear after periods on the diet. Evidently it builds up the children's resistance to the tubercle bacillus. Pottenger Sanatorium uses the same diet with good results in allergies and asthma.

When the food market again becomes normal, this sanatorium will resume some of the items in the original diet which have not been obtainable in recent years. These include raw bone meal, an excellent source of calcium; Chinese mung bean sprouts in green salad, rich in Vitamins B_1 and C, and visceral meats that will make up one third of the patient's daily protein consumption.

STOX . . . Granulated Bouillon

also saves Meat . . . saves Time . . . saves Money . . . and provides extra B vitamins

Dietitians everywhere find Stox, a "secret" of soups and sauces. This granulated bouillon has a hearty meat-like flavor that gives soups and sauces that magic savor.

Stox also helps to make your meat points go farther. It gives meatless dishes an appetizing meaty flavor—plus extra vitamin values. One level teaspoon of Stox supplies ¼ of the daily adult minimum B_1 requirement—and from a natural source.

Delicious as an instant clear bouillon, too! Once used in your menus, Stox will stay *for good!*

Ask your Standard Brands Man about STOX Granulated Bouillon a "Secret" of Soups and Sauces

FREE SEND TODAY FOR A "SECRET" OF SOUPS AND SAUCES

Standard Brands Incorporated
Hotel & Restaurant Dept., MH
595 Madison Avenue, New York 22, N. Y.

☐ Please send me the new free recipe folder, *A "Secret" of Soups and Sauces*

☐ Please send me free folder on facts about Stox, ". . . OF SPECIAL INTEREST TO EVERY DIETITIAN."

Name_____

Name of Institution_____

Address_____

City_____ State_____

Menus for January 1946

Lela Scherz
Roseland Community Hospital
Chicago

1
Grapefruit
Sweet Rolls
•
Tomato Bouillon
Roast Turkey With
Dressing
Mashed Potatoes
Peas
Cranberry Salad
Celery, Olives
Ice Cream
•
Cream of Turkey Soup
Assorted Sandwiches
Pickle Garnish
Green Gage Plums

2
Stewed Apricots
Scrambled Eggs
•
Broth With Rice
Liver
Escalloped Potatoes
Spinach With Lemon
Carrot Strips, Radishes
Cherry Cobbler
•
Split Pea Soup
Creamed Eggs on Rusk
Lettuce and Tomato
Salad, Mayonnaise
Tangerines

3
Bananas
Blueberry Muffins
•
Consommé
Roast Beef With Gravy
Mashed Potatoes
Julienne Carrots
Tossed Vegetable Salad
Ginger Bread With
Whipped Cream
•
Chicken Okra Soup
Spanish Rice
Bacon
Lettuce Salad,
French Dressing
Fruit Cup

4
Applesauce
French Toast, Sirup
•
Baked Trout
Parsley Potatoes
Stewed Tomatoes
Coleslaw
Lemon Pie
•
Lentil Soup
Russian Salad
Hard Cooked Eggs
Raisin Scones
Jam
Royal Anne Cherries

5
Stewed Peaches
Bacon
•
Tomato Soup
Beef Stew
Lettuce Salad,
Mayonnaise
Hot Parker House Rolls
Whipped Gelatin
•
Cream of Spinach Soup
Toasted Cheese Sandwiches
Mixed Vegetable Salad
Pineapple

6
Grapefruit
Sweet Rolls
•
Mushroom Broth
Maryland Chicken
Mashed Potatoes
Broccoli
Celery, Olives
Ice Cream With
Chocolate Sauce
•
Vegetable Soup
Baked Potatoes
Cottage Cheese and
Tomato Salad
Apricots, Cookies

7
Orange Juice
Poached Eggs
•
Scotch Barley Broth
Baked Ham
Sweet Potatoes
Green Beans
Cabbage and Carrot Salad
Grapefruit Custard
•
Beef Soup
Italian Spaghetti
Lettuce With Mayonnaise
Baked Apples

8
Bananas
Bran Muffins
•
Tomato Bouillon
Swiss Steak
Mashed Potatoes
Harvard Beets
Perfection Salad
Butterscotch Pudding
•
Vegetable Soup
Assorted Sandwiches
Pickle Garnish
Tangerines

9
Grapes
Scrambled Eggs
•
Beef Broth With Noodles
Meat Loaf
Creamed Parsley Potatoes
Julienne Carrots
Celery, Radishes
Chocolate Pudding
•
Cream of Tomato Soup
Canadian Bacon
Baked Squash
Glazed Apples
Ribbon Salad
Cup Cakes

10
Grapefruit
Bacon
•
Broth
Roast Lamb
Mint Jelly
Mashed Potatoes
Spinach
Spiced Pears
Steamed Pudding
•
French Onion Soup
Creamed Chipped Beef
on Rusk
Lettuce Salad
With Mayonnaise
Peaches

11
Kadota Figs
Poached Eggs
•
Consommé
Baked Salmon,
Lemon Slices
Parsley Potatoes
Baby Limas
Carrot Strips
Upside-Down Cake
•
Tomato Soup
Spiced Eggs
Cottage Cheese
Toast Points
Fruit Cup

12
Stewed Prunes
French Toast
•
Alphabet Soup
Chop Suey
Rice
Lettuce With
French Dressing
Hard Rolls
Snow Pudding
•
Vegetable Soup
Asparagus With
Cheese Sauce
Bacon on Toasted Bun
Apple, Date Salad
Cookies

13
Tangerines
Poached Eggs
•
Scotch Broth
Roast Beef
Mashed Potatoes
Cauliflower
Perfection Salad
Ice Cream
•
Bouillon
Tuna Salad
Potato Chips
Peaches

14
Prune Plums
Bacon
•
Tomato Bouillon
Meat Loaf
French Fried Potatoes
Peas and Carrots
Celery Cabbage Salad
Maple Nut Mold
•
Barley Soup
Canadian Bacon
Glazed Sweet Potatoes
Grapefruit Salad
Chocolate Cake

15
Sliced Bananas
Bran Muffins
•
Beef Broth
Liver
Spaghetti With
Tomato-Cheese Sauce
Celery, Carrot Strips
Fruit Gelatin
•
Cream of Corn Soup
Bacon
Apple Fritters
Lettuce Salad
Royal Anne Cherries

16
Grapefruit
Scrambled Eggs
•
Creole Soup
Roast Veal
Mashed Potatoes
Green Beans
Cranberry Relish
Peach Cobbler
•
Cream of Asparagus Soup
Assorted Sandwiches
Tomato Garnish
Green Gage Plums

17
Tomato Juice
Bacon
•
Broth With Rice
Swiss Steak
Mashed Potatoes With
Gravy
Julienne Carrots
Snow Pudding
•
Cream of Spinach Soup
Baked Potatoes
Cottage Cheese and
Tomato Salad
Fruit Cup

18
Stewed Prunes
French Toast, Sirup
•
Bouillon
Haddock Fillets
Parsley Potatoes
Stewed Tomatoes
Coleslaw
Apple Pie
•
Vegetable Soup
Macaroni and Cheese
Lettuce Salad With
Mayonnaise
Red Cherries, Cookies

19
Tangerines
Poached Eggs
•
Broth With Noodles
Baked Ham
Sweet Potatoes
Creamed Celery
Carrot Strips, Radishes
Norwegian Prune Pudding
•
Tomato Bisque
Creamed Chipped Beef
on Rusk
Waldorf Salad
Apricots

20
Grapefruit Halves
Cinnamon Toast
•
Consommé
Chicken à la King on
Baking Powder Biscuits
Peas
Celery, Olives
Ice Cream
•
Bouillon
Escalloped Potatoes
Cold Meat
Green Bean Salad
Prune Plums

21
Sliced Oranges
Scrambled Eggs
•
Chicken Broth
Roast Beef
Browned Potatoes
Glazed Carrots
Mixed Vegetable Salad
Chocolate Pudding
•
Cream of Mushroom Soup
Ham Salad Sandwiches
Peanut Butter and Jelly
Sandwiches
Relishes
Pears, Cookies

22
Sliced Bananas
Bacon
•
Vegetable Soup
Liver
Creamed Parsley Potatoes
Green Beans
Pickled Beets
Fruit Gelatin
•
Broth
Spaghetti With Meat
Balls
Lettuce Salad With
Mayonnaise
Baked Apples

23
Grapefruit
Bran Muffins
•
Tomato Bouillon
Meat Loaf
Escalloped Potatoes
Brussels Sprouts
Fresh Fruit Salad
Apricot Fluff
•
Consommé
Asparagus With Cheese
Sauce
Toast Points
Egg and Beet Salad
Fruit Cake

24
Applesauce
Scrambled Eggs
•
Barley Broth
Roast Veal and Dressing
Cranberry Sauce
Mashed Potatoes
Creamed Peas
Fruit Cup
•
Chicken Noodle Soup
Assorted Sandwiches
Relishes
Peaches

25
Stewed Prunes
French Toast, Sirup
•
Tomato Bisque
Baked Salmon
Parsley Potatoes
Spinach With Lemon
Coleslaw
Banana Cream Pie
•
Cream of Pea Soup
Spanish Rice
Bacon
Ribbon Salad
Cookies

26
Orange Juice
Bacon
•
Julienne Soup
Beef Stew
Baking Powder Biscuits
Lettuce Salad
Rice and Raisin Pudding
•
Cream of Spinach Soup
Cold Cuts
Escalloped Potatoes
Tossed Salad
Red Cherries

27
Grapefruit
Sweet Rolls
•
Tomato Bouillon
Roast Ribs of Beef
Mashed Potatoes and
Gravy
Cauliflower
Perfection Salad
Ice Cream
•
Consommé
Tuna Salad
Potato Chips
Pickle Garnish
Apricots
Hot Chocolate

28
Kadota Figs
Poached Eggs
•
Vegetable Soup
Roast Lamb, Mint Jelly
Glazed Sweet Potatoes
Harvard Beets
Celery, Carrot Strips
Grapenut Custard
•
Creamed Chipped Beef
Lettuce and Tomato Salad
Italian Cake

29
Stewed Prunes
Bacon
•
Broth With Rice
Beef Tenderloin
Mashed Potatoes
Peas
Tossed Salad
Chocolate Pudding
•
Cream of Tomato Soup
Chicken With Noodles
Lettuce Salad, Thousand
Island Dressing
Ginger Bread With
Whipped Cream

30
Grapefruit
Scrambled Eggs
•
Tomato Bouillon
Baked Ham
Candied Sweet Potatoes
Green Beans
Apple and Date Salad
Bread Pudding
•
Cream of Mushroom Soup
Vegetable Salad Plate
Hard Cooked Eggs
Raisin Scones, Jam
Pineapple

31
Orange and Grapefruit Juice, Blueberry Muffins • Consommé, Pot Roast of Beef, Mashed Potatoes and Gravy, Julienne Carrots, Celery, Radishes, Maple Nut Mold • Potato and Onion Soup, Toasted Cheese Sandwiches, Relishes, Fruit Gelatin

Ready-to-eat or cooked cereals are offered on all breakfast menus.

12-oz. Can Makes 4 Gallons of Beverage

and contains when packed, 1920 MG. VITAMIN C (ASCORBIC ACID), EQUAL TO 38,400 UNITS OF VITAMIN C, and 64 MG. VITAMIN B1 (THIAMINE HYDROCHLORIDE). EQUAL TO 21,312 UNITS OF VITAMIN B1.

The FINISHED BEVERAGE, made according to directions on label, will contain 600 UNITS VITAMIN C, and 333 UNITS VITAMIN B1, TO EACH 8-OUNCE GLASS.

These amounts are the daily minimum adult requirements, according to U. S. standards.

19 OUNCES OF FRESH NATURAL, TREE-RIPENED FRUIT JUICE WAS USED IN THE MAKING OF THIS 12-OUNCE CAN OF DEHYDRATED FRESHIE VITA CRYSTALS.

available in Orange, Lemon and Lime flavors

Food scientists for years have sought the answer to a way of dehydrating fruit juices that would *retain important food values* and *freshness* of flavor. Out of the laboratory of wartime necessity has come FRESHIE VITA CRYSTALS, truly a great nutritional achievement.

These delicious new dehydrated fruit juice flavors are developed by a new and exclusive process and are ***Easy to Prepare*** — Just add water to the dehydrated crystals and sweeten.

So Economical to Use—One 12-ounce can of FRESHIE VITA CRYSTALS makes 4 gallons of true fruit beverage, and costs only $1.50. Cost of 8-oz. glass of "Freshie", including sugar, is approximately 2½ cents and provides 600 units of vitamin C and 333 units of vitamin B1.

★

If you have not tried FRESHIE VITA CRYSTALS, send for details today.

SUNWAY Fruit Products

CHICAGO 11, ILLINOIS

Save Coal by Control

R. STARR PARKER
Power Plant Engineer
Cincinnati, Ohio

ECONOMIES effected in hospital operation are in direct proportion to the care exercised by the administrator in controlling the costs of individual departments.

The present policy of allowing the service departments to produce at any cost and by any means must some day come to an end. A return to accurate departmental control will then be made, with searching analysis of all items making up the individual costs of each department in the hospital.

The power plant is definitely one operating department that can be subjected to accurate controls if the proper tools for measuring the output of this department are available to the engineer.

Meters Control Costs

Metering equipment provides the information necessary to the administrator in exercising control over power plant costs. At the same time these instruments are essential to the chief engineer in establishing economical operating procedures.

Recent coal shortages have focused attention on boiler plant efficiency, but neither the administrator nor the chief engineer can accurately determine power plant efficiency without the proper metering equipment.

For the purposes of control by the administrator's office, indexes of power plant operation can be reduced to three fundamental units:

1. Per cent (by volume) of carbon dioxide (CO_2) in the gas, which is a measure of the efficiency with which the fuel is burned.
2. Flue gas temperatures, an indication of the efficiency of the boiler heating surface.
3. The ratio of the total pounds of steam produced to the total fuel burned, a measure of over-all boiler efficiency.

In the measurement of CO_2, a recording CO_2 meter should be installed for boiler plants of from 300 to 600 total horsepower, or for each individual boiler installation of approximately 400 h.p. and over.

When one recorder is installed for two or more boilers it should be connected by means of a manifold to each boiler in the group.

If the size of a boiler plant does not justify a recording CO_2 meter, a portable flue gas analysis set or a CO_2 analyzer should be provided.

A combination steam flow and air flow meter may be installed on boilers of 300 h.p. capacity or over in lieu of a CO_2 recorder and steam flow meter.

When flue gas temperature recorders are not installed on individual boilers a thermocouple in the last pass of each boiler, connected through a selector switch to a single recorder, may be substituted.

In small installations an indicating pyrometer (or thermometer) in place of recording equipment will be found useful if read at periodic intervals.

Flue gas temperature recorders can be incorporated with both CO_2 recorders and steam air flow meters, and when these instruments are used it is an economy to have this feature included.

Steam flow meters are a necessary adjunct to efficient operation of the boiler plant. They are indispensable in testing coals and without them the administrator can have no accurate report on the amount of steam produced.

The sole function of a boiler plant is the production of steam. To measure the efficiency of the plant it is necessary to know the quantity produced. The quantity of steam produced in a given period divided by the pounds of coal burned in the same period will give the pounds of steam produced per pound of coal burned, a figure that can be used to compare day-to-day operations or for checking operations with other plants. Coals, of course, vary in Btu. content and this factor must be considered.

Meters, like other equipment, must be given periodic maintenance if accurate, trouble-free operation is to be expected. Most plants find it an economy to go over all meters in the spring, at the end of the heavy winter loads, and also in the fall before increased demands begin again.

Follow Manufacturer's Suggestions

The recommendations contained in the instruction booklets of the manufacturer must be followed to the letter in making inspections and adjustments; if competent mechanics are not available, it will be an economy to arrange for inspection by a traveling factory service man.

Although the meters described will be adequate for supplying the administrator with data for comparing day-to-day and monthly operations of the power plant, there are other meters that might be requisitioned by the chief engineer to help him in establishing the most economical operating procedures and to assist him in meeting hourly fluctuations in demand and seasonal changes in load conditions.

Such meters would include draft gauges, recording thermometers, smoke indicators, feed water meters, automatic combustion controls and the like. In the interest of economical operation, it will be to the hospital's advantage to give sympathetic consideration to requests for appropriations for such equipment.

HOUSEKEEPING

Conducted by Alta M. La Belle

Employes "Belong" in a Uniform

MARY DeGARMO BRYAN
Head, Institution Management Department
Teachers College, Columbia University

FROM the standpoint of the public, the uniform of the employe, its attractiveness and fit and its immaculate appearance are of the utmost importance. That uniform, properly worn, is worth a million dollars in public relations value—and it must be appropriate.

At one of the large New York hotels recently, I noticed that the elevator starter was wearing a nicely tailored uniform but she had on the kind of shoes one would wear to a tea in that hotel—open toes, open heels, high heels. A part of the uniform is the whole uniform and it is not proper to wear such shoes with a tailored garment. Half a dozen smartly dressed men and women standing near me commented on the incongruity of the costume and said: "Wouldn't you think a hotel of this type that spends so much money on uniforms would at least see that she was smartly dressed to the ground?"

It Goes All the Way Down

A uniform does go all the way down to the ground and the way the employes carry themselves is as important as the uniform itself. They should be given training in posture and gait—and, believe it or not, they love it. Such training can be given as a part of a style show when the uniforms are issued and employes are greatly impressed when they are shown how to stand and walk.

A uniform develops in the employe a group consciousness. It gives him a feeling of belonging to the organization or department in which he works. That is a significant bit of psychology and is of importance to the department head.

Many of the part-time employes at Teachers College, Columbia University, are housewives who have never before worn uniforms of any kind. They are a little bit afraid of a job to begin with, but we have found that when we put them into uniform and tell them how to stand and how to do their hair, the whole ensemble gives them a feeling of "Well, this is not so bad; other people are doing it. I belong to this group." From the standpoint of morale, such an attitude is highly important.

Incidentally, we have found that our women employes will not wear caps. To many of them, a woman's cap is a badge of servitude. Caps are often not becoming anyhow, so why make an issue of it? We substitute hair nets and they serve the same purpose.

A uniform should be considered from the employe's point of view. Practicality is not necessarily the chief criterion, but we should be able to combine practicality with morale building without detriment to either.

Of prime importance is the effect of a uniform on the employe's appearance. Recruiting officers from the Wacs are convinced that the Waves had less difficulty than the Wacs in recruiting because Navy blue is more becoming to young women than is khaki.

What we look like, unfortunately, is not always what we think we look like. When we were able to obtain anything except white uniforms, we used to have style shows at Teachers College and allow the employes to pick out the colors they wanted or to modify the styles here and there. Employes should certainly aid in the selection of their uniforms but they must be guided a little, without their knowing it, or the results will be amazing.

One summer, for instance, the older women decided that they wanted a uniform of a blue that would have made the most ravishing movie blonde wash out of the picture, but they could not be dissuaded and we had to let them have it. They are still wearing those uniforms.

When considering color selection, we must remember that we are entering an era of many new developments in lighting. In public institutions, particularly, there is going to be immediate use of new lighting of all types—not only in working areas, but in public places. Therefore, the colors selected for the uniforms will have to be considered and observed under the new lighting or the effect will be entirely different from that originally contemplated.

Must Be Suitable to the Job

Uniforms must be comfortable. If an employe is conscious of his clothes he is uncomfortable and does not do his best. Therefore, after appearance, the next point to consider is comfort. The uniform must also be suitable to the job that is being done and it must be easy to maintain.

The war has brought progress so far as clothing is concerned. The expert tailoring in military uniforms has, it is hoped, led those uniform manufacturers who turned out fuddy-duddy styles year in and year out, to make something really new in uniforms. There is no reason why the good styling and construction that have gone into outfitting our armed forces shouldn't carry over into our institutional uniforms.

Without question, many of the new textiles are going to interest us. For example, at Teachers College we have occasionally been able to obtain nylon blouses that were made from rejects from the parachute manufacturers. They are perfectly delightful items and, after washing, require no pressing. The housekeeper should, therefore, be interested in the possibilities of nylon for uniforms, as well as for draperies and upholstery fabrics.

New finishes given to textiles have been almost entirely reserved for the

From a talk given at the eastern district meeting, National Executive Housekeepers' Association, May 1945.

★ ★ ★

★ An army nurse on a Vox Pop *radio program* told the world

★ Answering a question last winter she told the lay population that "T.L.C." was the armed service nurse's patois for "tender loving care." No doubt it expresses the aim of hospitals everywhere. No doubt the same thought should be, and eventually will be, built into all hospital equipment when possible. ¶ When Formica laminated plastic is used for panelling purposes, and all furniture, bedside tables and overbed table tops, this thoughtfulness actually is possible. ¶ Formica comes in cheerful colors. It is very easy to keep clean. Food, drinks and ordinary medicines do not spot or stain it. It looks as clean and wholesome and sanitary as the nurse. Its beauty, like hers, helps people get well. But unlike her it never gets tired; and its beauty never fades or needs touching up. To choose it for the new building, the new wing or the remodeling is to put T.L.C. into practice.

The Formica Insulation Company
4629 SPRING GROVE AVENUE, CINCINNATI 32, OHIO

FORMICA

armed forces, but we shall benefit from them later. There are water and dirt repellent treatments that will be extremely useful and also a sanitizing treatment which was getting under way a little while before the war but which thus far has been limited to shoe linings. In hospitals and hotels, in which there is the possibility of carrying germs from one room to another, the sanitizing process is going to be extremely valuable.

In addition to being better designed and made of new materials, uniforms ought to be improved through the use of some of the new plastics that should make attractive buttons or trimming. Or we might leave off buttons entirely and use plastic zippers, which are most pleasing and will stand laundering.

Uniforms must be selected with a sense of the decoration of the building and of the location of the employes within the building. Just before the war, I was at a hotel at Crater Lake in Oregon. This is a magnificent lake in the crater of a volcano and the colors of the lava are reflected in it. The hotel is so situated that the dining room looks out on this lovely picture and the uniforms of the waitresses and of the bus boys picked up the colors in that lake and of the lava. The uniforms were changed with each meal so that there was a different assortment of colors. The effect was extraordinarily beautiful.

The last point I want to make about uniforms is that they must be immaculate. Whatever the color, size or shape, if they are not perfectly fresh, it would be better not to have them at all. Uniforms should be laundered and cared for by the institution so that the housekeeper is free to insist on an immaculate appearance at all times.

Now that civilian production is beginning again, the members of the National Executive Housekeepers' Association could render a valuable service by offering their institutions as research laboratories for the manufacturers of uniforms. Many of the large uniform manufacturers would be glad to experiment on various styles and types and designs of uniforms, as well as on launderability, ease of cleaning and wearing quality. No one is better qualified than are the executive housekeepers to carry out such a study.

Uniforms are a big item in both original cost and cost of maintenance and they are essential from the standpoints not only of publicity and public approach but of the efficiency and happiness of the worker. So, not in the cheap and shoddy sense, but in a very real sense, clothes make the man because they give him pride in his job and pride in himself. Uniforms do build morale.

Moths Allergic to White

"Color in hospitals is all well and good and we need more of it," a housekeeper remarked the other day. "There is one place, however, where I shall always insist on clear white, and that is closets. The reason is probably well known to many but sometimes a little reminder does no harm. Moths don't like white; they will always choose darker surfaces; consequently, it is safer to stick to white for closets, cupboards, attics, basements, storerooms, any place that might attract these pests. And don't confine your painting to the walls and ceiling, give the floor a coat of white as well."

Recommended for **STANDARD PROCEDURE . . .**

The same bed pan cover should not be used for more than one patient

—From "Standards and Recommendations" issued for hospitals by New York City Department of Health.

The NEW A. S. R. SANITARY BED PAN COVER

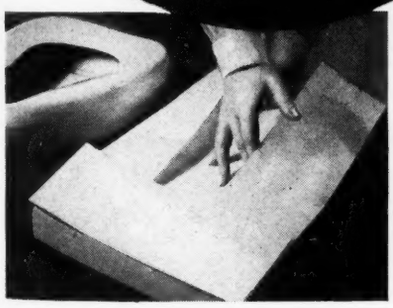
INDIVIDUAL.. DISPOSABLE...

Bed pan technique should measure up to top standards of institutional practice.

Many hospitals are finding the efficient answer in the A. S. R. Sanitary Bed Pan Cover—made of easily disposable paper.

Safeguards patients from communicable diseases and dangers of cross infection. Cuts laundry cost and routine. Eliminates repairs and replacement of lost covers. *Inexpensive.*

Extremely easy to use. The cover envelops sides of pan as well as top, sealing in objectionable odors. Printed panel provides convenient space for patient's record.



1. Cross hands, grasp flaps.

2. Flip cover over pan.

3. Guide cover into position.

PRICE LIST

Quantity	White Paper	Brown Paper
One to four M	$15 per M	$10 per M
Five to nine M	$13.50 per M	$9 per M
Ten M and over	$12 per M	$8 per M

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NEWS IN REVIEW

A.M.A. to Speed Prepayment Plans for All States in National Voluntary Program

A national system of state-administered prepayment medical plans sponsored by physicians is the objective sought through action taken by the American Medical Association's House of Delegates at its meeting in Chicago December 3 to 7. The Council on Medical Service and Public Relations was instructed to take immediate steps to aid the organization of state plans throughout the country and to integrate new and existing plans into a uniform national program.

This action, which was taken by the delegates in a meeting on December 5, followed three days of discussion during which a number of speakers made clear the belief that positive steps by the association were necessary to forestall passage of President Truman's national health plan.

Considerable discussion developed over the comparative merits of medical service plans and cash reimbursement plans, with most of the delegates apparently favoring the service type. However, the resolution passed by the house did not specify which kind of prepayment plan was to be organized in any state.

Dr. Harrison H. Shoulders, speaker of the House of Delegates for several years, was named president-elect of the association. He will succeed Dr. Roger I. Lee of Boston, who became president at this meeting. Dr. Roy Fouts of Omaha succeeded Doctor Shoulders as speaker, and Dr. William R. Maloney of Los Angeles was named vice president.

Dr. George Minot was given the A.M.A.'s award of merit.

Earlier in the week a resolution designed to effect the removal of Dr. Morris Fishbein, editor of the A.M.A. *Journal* for more than twenty years, failed to gain any considerable support among the delegates, as did another resolution, plainly aimed at Doctor Fishbein, which would have restricted outside activities on the part of employes on the A.M.A. staff.

The house voted unanimous disapproval of Senator Pepper's pending legislation to expand the present program of federal aid for infant and maternal welfare and child care. The delegates also recommended that the Children's Bureau, which administers this program, be transferred from the Department of Labor to the U. S. Public Health Service.

San Francisco was named as the site of the association's 1946 convention, which will be held during the week of July 1.

Pharmacy Association Offers Aid to Vets

WASHINGTON, D. C.—At the annual joint meeting of the council of the American Pharmaceutical Association and the executive committee of the National Association of Retail Druggists, these executive groups offered to cooperate with the Veterans Administration on problems of returning pharmacist-veterans.

Other actions taken in the joint meeting were: concrete assistance to pharmacists in improving relations with physicians on prescription practice; strong opposition to low standards of the Civil Service Commission for recruiting pharmacists; approval of the formulation of a uniform law to control misuse of barbiturates, and endorsement of a proposed business branch exclusively devoted to the development of small business.

The executive groups also expressed the belief that the inauguration of a five year course in pharmacy should be deferred until the need can be more definitely shown and until the opportunities open to pharmacists more clearly justify such an extension of the course.

H.R. 4225, now before Congress, provides appointment of a group of pharmacy officers in the department of medicine and surgery in the Veterans Administration. While approving appointment of such commissioned pharmacy officers, the conference urged amendment of the bill to create a separate pharmacy corps and to make the appointment of a chief pharmacist mandatory rather than optional.

Propose License Law for Practical Nurses

WASHINGTON, D. C.—Commissioners of the District of Columbia continued hearings through December 3 on the proposal to enact a law for the licensing of practical nurses in the District. Dangerously incompetent practical nurses are allowed free rein in Washington today, Dr. Joseph S. Wall, chief of staff at Children's Hospital, declared in urging the need for regulation of practical nurses under the Nurses' Licensing Act. Doctor Wall represented the District Medical Society, which has approved the amendment.

V.A. Nursing Groups Inaugurate Teaching and Study Programs

By EVA ADAMS CROSS

WASHINGTON, D. C.—Nurses representing seven Veterans Administration hospitals in the Boston Branch Area met in Bedford, Mass., November 26 in the first of a series of teaching institutes.

Outstanding leaders in nursing education addressed the week-long gathering. Among the speakers were Gwen Andrew, superintendent of Veterans Administration nurses, and Lois Gordner, assistant superintendent of nurses and educational director, who presided as moderator.

A few days earlier, the newly formed nursing advisory council to the Administrator of Veterans Affairs held a two day session in Washington. The council represents the professional interests of more than 5000 V.A. nurses.

Members of the council are: Katherine J. Densford, director of the University of Minnesota School of Nursing, Minneapolis; Sister Olivia Gowan, dean of the school of nursing education, Catholic University of America, Washington, D. C.; Marion G. Howell, dean of the Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland; Sallie Jefferies, director of nursing, U. S. Department of the Interior, Office of Indian Affairs; Ruth Sleeper, assistant principal of the Massachusetts General Hospital, Boston.

As of September 30, 1945, there were 1341 cadet nurses assigned to various veterans' hospitals for the last six months of their training, Miss Gordner said in an interview, and 2000 more are waiting for assignment. In April 1944, one veterans' hospital was cooperating in the cadet nurse training program; now 36 hospitals are taking part.

There are 13 affiliated schools in the student nurse program using four V.A. hospitals. Tuskegee opened this program in October 1943 with one affiliate. On Nov. 1, 1945, 357 student nurses had completed their affiliation service. Veterans Administration hospitals having affiliate student nurses are Hines, Ill.; Murfreesboro, Tenn.; Sheridan, Wyo., and Tuskegee, Ala.

Plan Mental Health Institute

WASHINGTON, D. C.—The National Mental Health Institute Bill has been approved by a House subcommittee and reintroduced with a few changes. According to Representative Priest, who introduced it, the bill remains the same in principle and the changes are not significant. The bill would authorize a sum of $4,500,000 to establish a National Institute of Mental Health in the District of Columbia.

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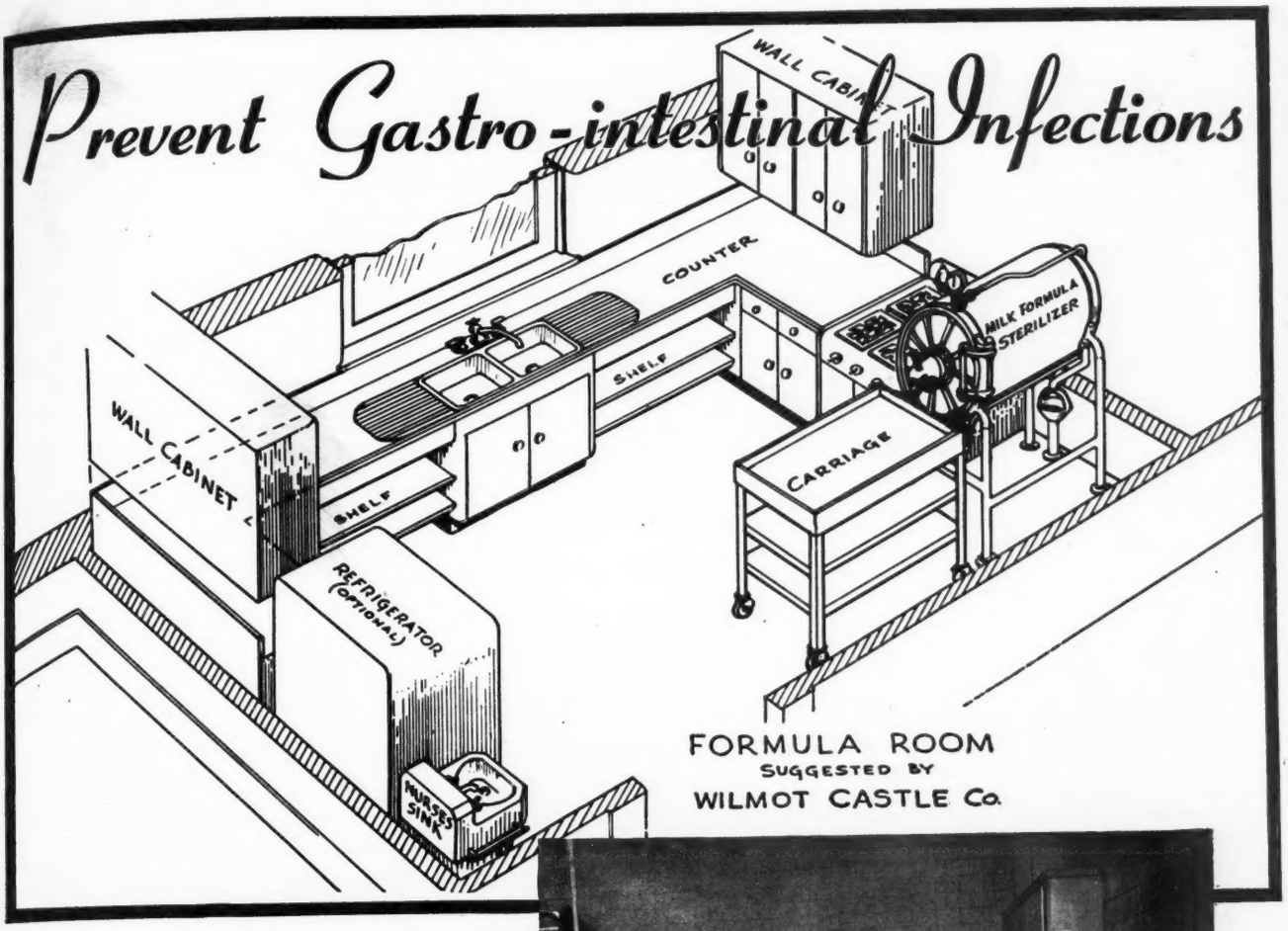

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Asks Higher Pay for Doctors and Nurses of Veterans' Hospitals

WASHINGTON, D. C.—Legislation should be enacted to provide salaries sufficient to induce outstanding physicians, nurses, pathologists and other high caliber personnel to accept and retain jobs with the Veterans Administration. This was the gist of testimony given by Maj. Gen. Omar N. Bradley before the Senate Committee on Civil Service in November.

The testimony was given concerning a bill to increase the rates of compensation of officers and employes of the federal government. Such legislative relief, said General Bradley, is one of the most urgent needs of the Veterans Administration.

Bernard Baruch specifically recommended substantial increases in salaries of doctors, nurses and technicians in his report to Administrator Bradley some months ago. Mr. Baruch also recommended: promotion on professional ability and skill instead of seniority; freeing doctors from needless paper work through more efficient hospital administration; ample opportunities for doctors to grow professionally through post-graduate and refresher studies and through effective ties with centers of medical education and skill; ample research facilities, and encouragement of research by veterans' doctors.

Army Hospitals to Be Released as Men Leave

Release by the Army by January 1 of 23 hospitals out of its war-time peak of 65 has been announced by Maj. Gen. Norman T. Kirk, surgeon general. The hospitals will be offered to the Veterans Administration or given back to their former owners, in the case of leased properties.

Additional hospitals will be released after the first of the year, but the schedule for such release cannot be forecast at this time, General Kirk declares. "As the number of men being cared for in any hospital decreases to the point where it is uneconomical to maintain it as a separate institution, the patients and facilities are consolidated into more efficient and workable units," the general explains.

The peak patient load of hospitals in the United States, reached at the end of June 1945, was 318,000 and has been dropping slowly ever since, despite the influx of men from overseas theaters. The Medical Department estimated that by January 1 this total will have declined to about 220,000 patients and that by June 1947 there will be only 70,000 men remaining in Army hospitals.

Wagner-Murray-Dingell Introduce Bills to Implement Truman Message

By EVA ADAMS CROSS

WASHINGTON, D. C.—A bill proposing to establish a national health insurance program along the lines set forth by President Truman in his five-point message to Congress was introduced November 19 by Senators Wagner and Murray. Representative Dingell introduced a companion bill in the House on the same day.

Although Mr. Truman maintains that his plan is not "socialized medicine," he recommended that legislation be enacted which would provide compulsory health insurance to finance medical care.

Briefly, the President's recommendations include: construction of hospitals and related facilities; expansion of public health, maternal and child health services; medical education and research; prepayment of medical costs, and protection against loss of wages from sickness and disability.

The Wagner-Murray-Dingell "National Health Act of 1945" contains three titles: Title I—Grants to States for Health Services; Title II—Personal Health Service Benefits, and Title III—General Provisions.

Title I contains three parts: grants to states for public health services; grants to states for maternal and child health services; grants to states for medical care of needy persons. In general, the purpose of this title is to amend and broaden existing legislation by eliminating existing restrictions so that present state and local programs can operate more effectively.

Title II of the bill provides for a system of prepaid personal health service benefits. Section 212 establishes a personal health services account, out of which all the benefits under this title are to be paid. The bill does not specify a particular method by which the sums authorized to be appropriated under section 212 would be raised.

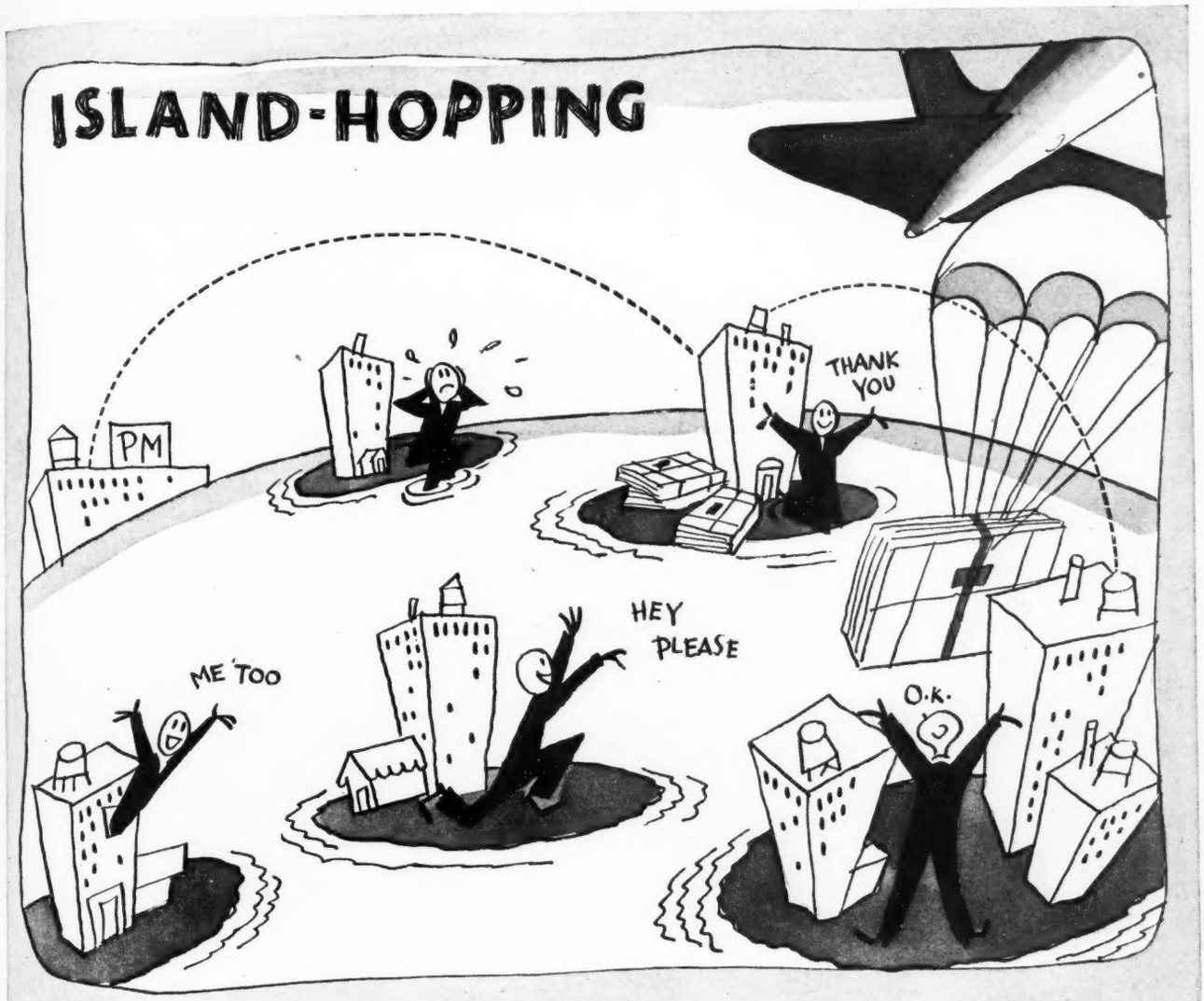
Freedom of medical practice is carefully safeguarded, according to Senator Wagner. Each person is allowed to choose his own family doctor. Each doctor or group of doctors is free to go in or stay out of the system. The bill makes a place for voluntary hospitals, group service organizations, existing voluntary insurance or prepayment plans and similar agencies, Senator Wagner maintains. All qualified hospitals, medical groups and organizations will be able to participate in the program, it is alleged. They will receive fair payments for the services they furnish under the bill and they will have enlarged opportunities to be service agencies for particular groups or for their communities.

Under provisions of the bill, hospital care is limited to sixty days a year, with a possible maximum of 120 days if experience proves that such benefits can be afforded. All qualified hospitals are eligible to participate.

There is no specific provision in the bill for hospital construction. However, Senator Wagner commented especially on the fact that S. 191, the hospital survey and construction bill, has already been favorably reported out. He considers such a bill an important beginning but adds that there must also be an insurance system to cover hospitalization costs in order to make sure that hospitals will be used by sick persons.

Jamaica to Add 300 Beds

A campaign to raise $2,300,000 for Jamaica Hospital, Queens, N. Y., has been announced. This will add 300 beds, making it the largest voluntary institution in that section. All but $150,000 of the amount to be raised will be used in the construction and equipment of a new five story building.



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Hospitals to Get Surplus Property at Discount Under New Ruling

WASHINGTON, D. C.—Nonprofit hospitals are given the privilege of acquiring greatly needed facilities and equipment at a substantial discount through Surplus Property Administration Regulation No. 14.

Under the regulation, disposal agencies will allow a discount of 40 per cent from the fair value of the property on orders by or for nonprofit hospitals and similar institutions. Fair value is a price not to exceed the lowest price offered at any trade level at the time of acquisition.

The regulation is designed to channel surplus goods on the basis of need to nonprofit hospitals, medical, sanitation and research institutions and other organizations of the kind. Hospitals will have a wide range of material and property from which to choose, it is reported. They may be able to get not only surgical instruments, dressings, drugs, laboratory equipment, hospital sheets and steam tables but also training films, bulldozers, plumbing equipment, heaters, trucks and a variety of other items.

The Federal Security Agency has set up a new office operating directly under the administrator to carry out the disposal of surplus properties assigned to it. Divisions of Surplus Property Utilization have been established in the Public Health Service and the Office of Education. Senior Surgeon J. O. Dean heads the Public Health Service division.

F.S.A.'s part in the disposal and distribution of surplus property is to act as liaison between the federal disposal agencies and the states, communities and nonprofit organizations which are eligible to apply for available property.

The Division of Surplus Property Utilization of the Public Health Service will handle and review cases involving medical institutions. It will determine an applicant's eligibility for discount. Procedure to apply for acquisition of property will be inaugurated by the F.S.A. with the approval of the Surplus Property Administration. Lists of nonprofit hospitals and other institutions eligible for the benefits provided under the regulation will be made.

To permit nonprofit institutions to exercise their purchase privileges, disposal agencies will notify them of available property. Such institutions will have the right on request to be placed on current mailing lists of disposal agencies.

Doctor Demobilization Rapped

WASHINGTON, D. C.—Although both Army and Navy claim sizable returns to civil life of doctors from the armed services, Senator Clyde M. Reed of Kansas introduced a resolution November 6 which would call for an Army board of inquiry into the "altogether bunglesome handling" of doctors in the Surgeon General's Office following the end of the war. Senator Reed declared he had received letters from all over the world complaining of this situation. Numerous state medical associations had written urging him to help get doctors out of the Army, the Senator claimed.

Griffith Named Hospital Head

Dr. Charles M. Griffith, director of medical services for the Veterans Administration since 1931, has been appointed manager of Mount Alto Hospital, Washington, D. C., Maj. Gen. Paul R. Hawley, surgeon general, announced today. Doctor Griffith succeeds Dr. Louis G. Beardsley, who becomes executive assistant surgeon general. The Mount Alto Hospital was one of three V.A. hospitals which gave postgraduate instruction to the medical staffs of the administration in prewar days. The courses stopped during the war because of a shortage of medical personnel.

Selective Service HQ Interprets Veterans' Reemployment Rights

Interpretation of returned veterans' statutory reemployment rights and legal protection provided to employers has been announced by national headquarters of the Selective Service System.

The veterans' rights do not depend on whether they were hired during the war production expansion period, according to the Selective Service statement which said, "The law denies reemployment rights to veterans who left 'temporary' positions. It is the opinion of Selective Service that all war jobs are not 'temporary' simply because such jobs were created as the result of war expansion."

The interpretation came as the result of various reports that employers had tried to fix a certain date on which their war activities began and thus claim that all employes hired after that date were "temporary." Selective Service explained that no such date could be fixed as a criterion on which statutory reemployment rights might or might not be claimed.

Employers are protected under law from undue hardship in that an employer is not obligated to reemploy a veteran if circumstances have so changed as to make it impossible or unreasonable to do so. "Obviously," said the statement, "if the returned veteran's job no longer exists and no position of like seniority, status and pay exists within the company's activity, the employer can not be required to create a job in order to fulfill the law."

$2,500,000 Medical Center to Be Built at Beirut

Plans for construction of a medical center at the American University of Beirut, Lebanon, the largest American educational institution outside the United States, have been announced by Albert W. Staub, American director of the Near East College Association, Inc. The $2,500,000 project will increase the bed capacity of the present hospital by more than 250 per cent, make possible the training of 25 per cent more medical students and the trebling of the nursing school. Work is expected to start this spring and will require sixteen months for completion.

Mr. Staub predicted that when the center is in operation, American medicine will come into the foreground in the Near East and that the center will benefit not only the Near East and the university but also the United States, offering improved hospital facilities for the personnel of the increasing number of American industries located in that part of the world.

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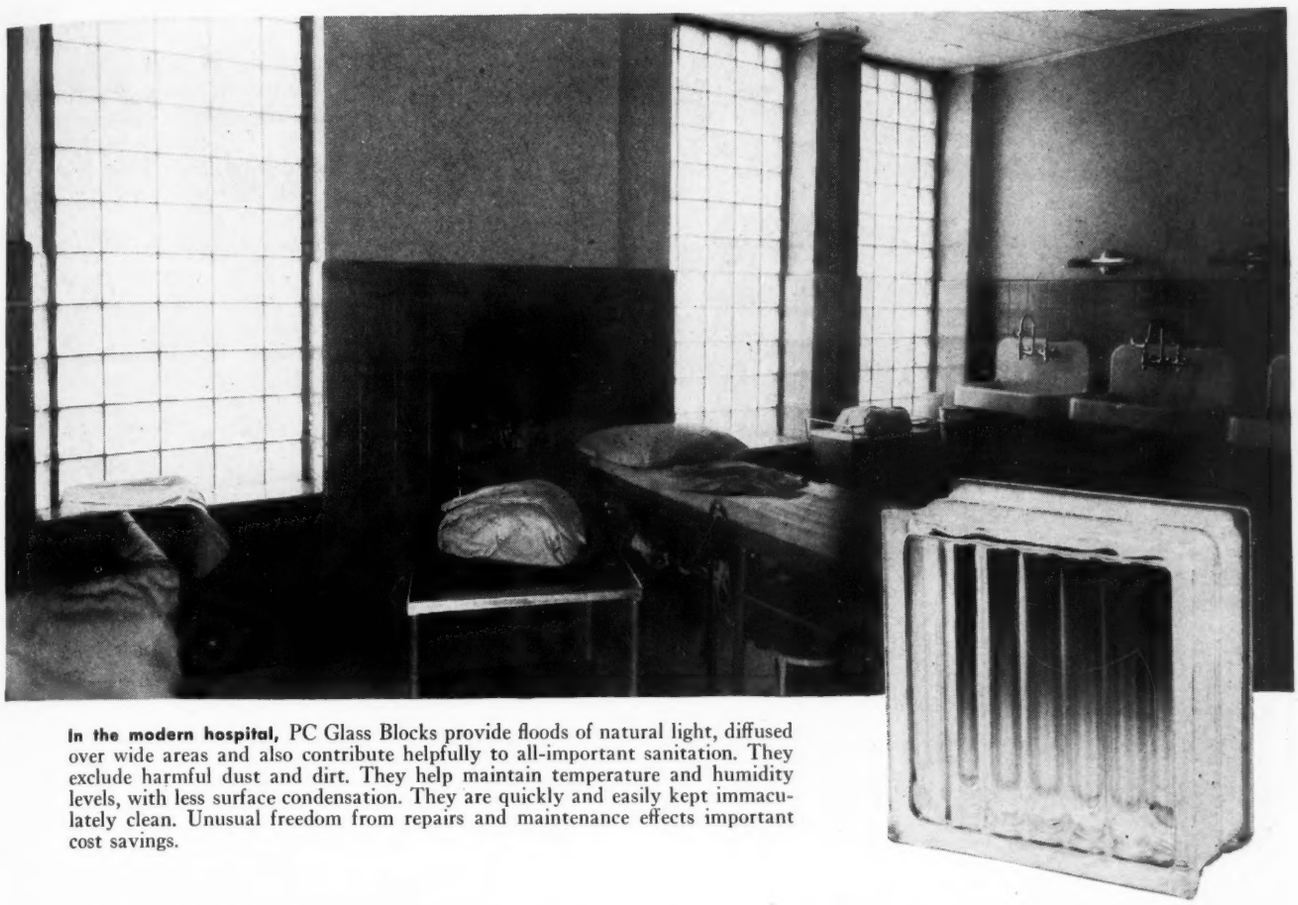

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Report Blasts St. Elizabeth's Hospital; Recommends Changes That Should Be Made

By EVA ADAMS CROSS

WASHINGTON, D. C. — St. Elizabeth's Hospital, federal institution for the treatment of mental disease, is overloaded with patients, its physical plant is badly in need of improvement and its medical services are inadequate, according to a recent report of the Public Buildings Administration. The survey was made at the request of the hospital officials themselves. In addition to the survey of physical conditions, a study of the hospital's psychiatric and medical services was made by three medical authorities.

More than a third of the buildings were classed as being in poor condition; one building, housing 318 patients, was criticized as a dangerous fire hazard which should be demolished immediately. P.B.A. found 7356 patients in the hospital, whose peak capacity is 6025.

Other conditions in need of correction as shown by the report were: the deplorable food distribution and serving facilities; inadequate toilet, laundry and storage facilities and water supply system, and the extremely poor condition of the occupational-physical therapy building. A great majority of the present buildings do not contain many essential treatment facilities and lack good light and ventilation and good planning, the report said.

A number of recommendations for improvement of the physical plant were made, calling for: a new nurses' home, a new laundry, new quarters for the superintendent, replacement of the occupational therapy building, improvement and extension of therapy units throughout the hospital, numerous remodeling jobs and many replacements. Also recommended were beauty parlors for women and barbershops for men, as well as a dry cleaning plant.

Medical authorities called on for a study of the hospital's medical services were Dr. Edward A. Strecker of Philadelphia, an adviser to the Navy on psychiatry; F. W. Lorenz, director of the Wisconsin Psychiatric Institute, and J. H. Musser, head of the medical department of Tulane University. Their reports submitted independently indicated the need of additional facilities, a larger medical staff and more interns. Doctor Strecker recommended an enlarged psychiatric staff, improvements in certain elements of psychotherapy and a playground for women patients.

Radio Drama Tells Story of Mental Health

A campaign to give the people of Connecticut a better understanding of mental illness started last month in the form of a radio drama called "The Story of Louise Mapleton." The program is jointly sponsored by the Connecticut State Hospital at Middletown and the Connecticut Society for Mental Hygiene, and it is believed to be one of the first dramatized presentations sponsored by civilian public health agencies on the subject of mental health. The story is based on a recent case history taken from the files of the Connecticut State Hospital. It describes in dramatic episodes the various stages through which a young mother passed during an attack of mental illness, both at home and while under treatment at a state hospital.

Teaching Program Planned

A teaching program will be established between Lenox Hill Hospital, New York City, and New York University College of Medicine for graduate, postgraduate and undergraduate work. A special committee on medical education has been created by the hospital to act as liaison between the college and the hospital in planning this program.

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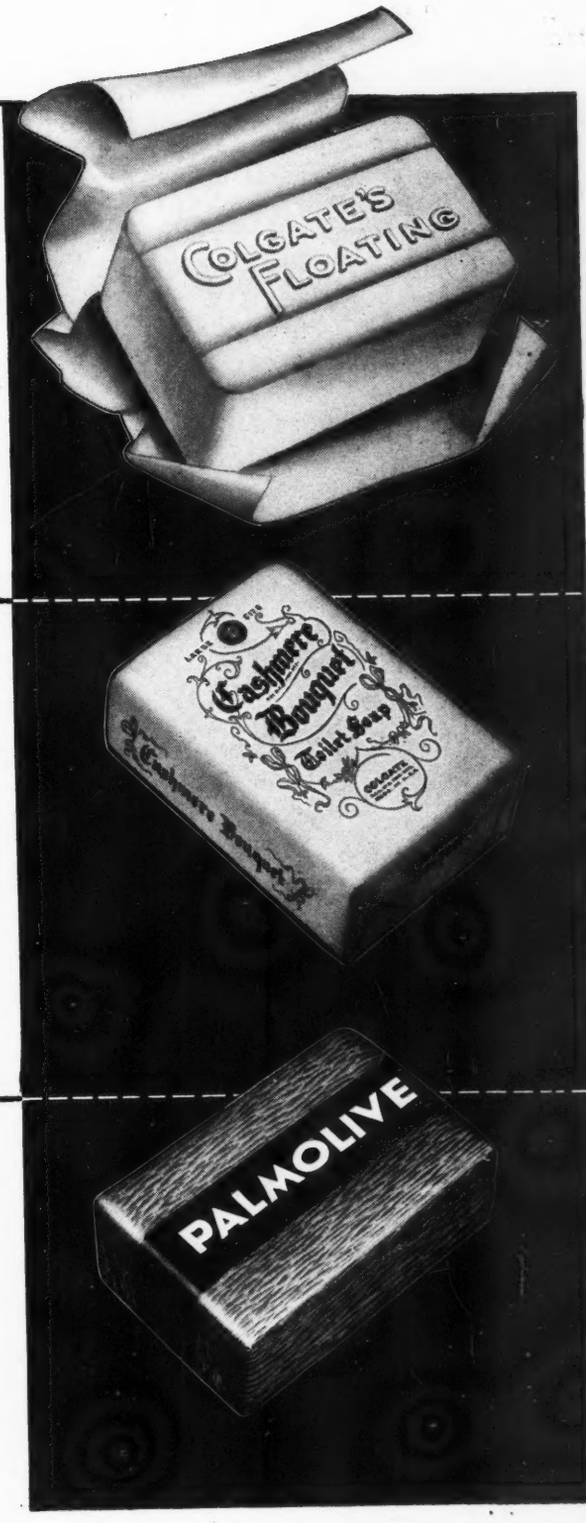

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V.A. to Intensify Research to Improve Artificial Limbs

WASHINGTON, D. C.—The Veterans Administration will become the central federal agency for all research and development work on prosthetic appliances after January 1, according to a recent announcement. This permanent research and development program is concerned only with the long-range future aspects of the problem. It seeks to develop the best and most modern appliances but does not include instruction as to their actual and immediate use.

To meet this vital phase of the problem, Maj. Gen. Paul R. Hawley has appointed Walter M. Bura as director of prosthetic appliance service in charge of all amputee rehabilitation for the Veterans Administration. Himself an amputee with a degree in mechanical engineering, Mr. Bura has worked with the Office of the Surgeon General of the Army in standardizing amputee rehabilitation procedures. He expects to maintain close cooperation with the Army, the Navy and the Committee on Prosthetic Devices in order to give the veterans advantages of all research.

In the meantime, the Army is conducting research work at Army amputation centers. Each hospital has been assigned to do a specific phase of prosthetic research and, it is anticipated, the results will be combined in a coordinated and more adequate artificial limb program for disabled veterans. General improvement in the quality of artificial limbs is sought, as well as more standardization of parts and the facilitation of production and fitting.

Walter Reed Hospital is conducting an intensive research program in the development of an artificial hand. Hospital officials say that the new artificial hand will closely approximate the human hand in utility and appearance. New materials and technics are under study in an attempt to produce a hand that will combine and improve on the functions now performed by two separate devices, a cosmetic hand and a hook.

In a recent report, Rep. Augustine B. Kelley, chairman of a Congressional subcommittee on the physically handicapped, recommended that the Board for Prosthetic and Sensory Devices and its work should be transferred to the United States Public Health Service.

The Veterans Administration, the report stated, has no tradition of successful research or scientific excellence, whereas the Public Health Service has a long record of fine scientific and medical work, is staffed with excellent scientific personnel and knows the technic of working with doctors.

COMING MEETINGS

ARKANSAS HOSPITAL ASSOCIATION, Hotel Albert Pike, Little Rock, May 17-18.

ASSOCIATION OF CALIFORNIA HOSPITALS, San Francisco, April.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Greenville, S. C., May 22-23.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Pennsylvania, New York City, June 10-12.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Hotel Bellevue Stratford, Philadelphia, April 24-26.

IOWA HOSPITAL ASSOCIATION, Hotel Fort Des Moines, Des Moines, April 15-17.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Brown, Louisville, April.

LOUISIANA HOSPITAL ASSOCIATION, Hotel Washington-Youree, Shreveport, March 22.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, April 24-26.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Morrison Hotel, Chicago, Feb. 6-7.

NATIONAL CONFERENCE OF SOCIAL WORKERS, Buffalo, N. Y., May 19-25.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 11-13.

NEW YORK STATE HOSPITAL ASSOCIATION, New York City, June 10-12.

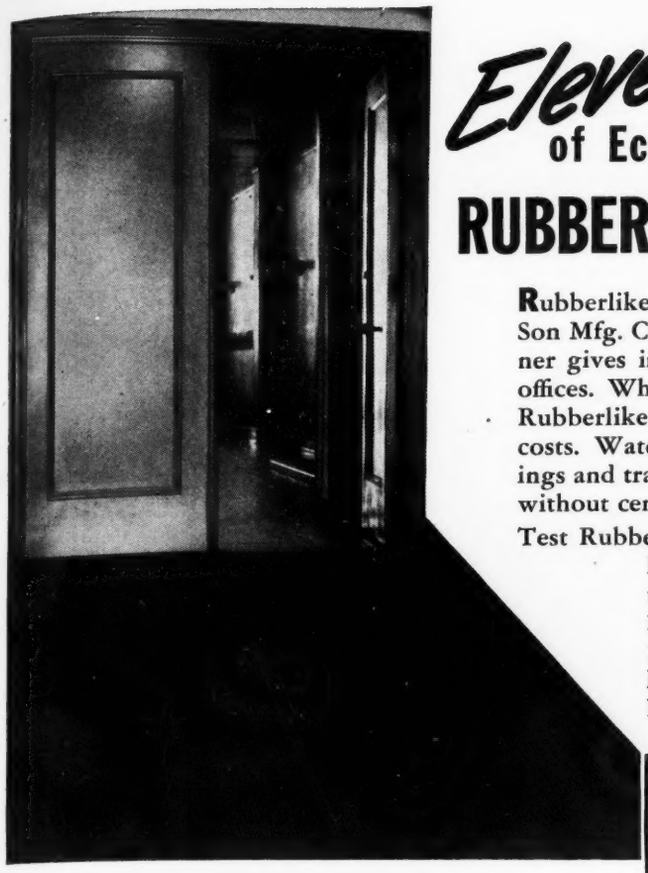
NORTH DAKOTA HOSPITAL ASSOCIATION, Hotel Ryan, Grand Forks, May 9-10.

OHIO HOSPITAL ASSOCIATION, Hotel Deshler-Wallick, Columbus, April 2-4.

TEXAS HOSPITAL ASSOCIATION, Hotel Texas, Fort Worth, March 21-23.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

WISCONSIN HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, February.



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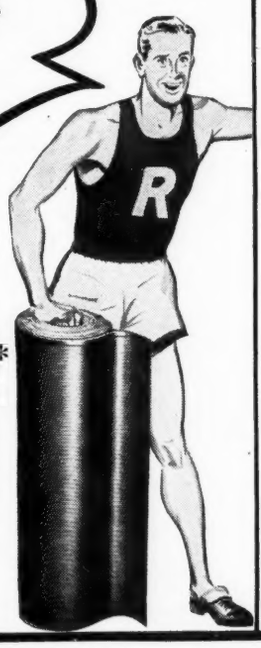

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St. Louis Adds Benefits; Rhode Island Reports 45 Per Cent Enrolled

In Rhode Island and in Missouri, impressive increases in enrollments have been reported in Blue Cross plans.

The St. Louis plan leads the country in new members protected since the end of the European war and has been able to retain the membership of 72 per cent of those whose employment status has been upset by reconversion, a recent announcement stated.

The fifteenth benefit added since the plan started in June 1936 provides an increase in care from thirty to sixty days for each member of the family at no increase in cost, according to Ray F. McCarthy, executive director of Group Hospital Service of St. Louis, which serves Missouri and southern Illinois. Services have been widely extended to rural Missouri during the last five years.

G. M. Congdon, president of the Rhode Island Blue Cross, reported at a recent meeting of the executive committee that a new high of 319,241 subscribers had been realized. The new memberships, he said, represent 45 per cent of the state's population—the highest percentage of any statewide Blue Cross plan in the nation.

Sydenham Receives $425,000 Toward Campaign Goal

More than 5800 contributions totaling $425,000 have been received by Sydenham Hospital, New York City, in its campaign for public support of its program to become firmly established as the country's first inter-racial voluntary hospital. In reporting progress to date, Harry C. Oppenheimer, president of the institution, emphasized the need for continuing the reorganized hospital's campaign to raise $600,000 before the end of 1946.

The final objective of the campaign, $600,000, is being used to modernize the present hospital plant, Mr. Oppenheimer said. "We also need new equipment and funds to meet operating deficits during our reorganization period," he explained.

The hospital has added six Negroes and 11 interested white persons to its board of directors and has admitted 24 Negro physicians to its medical staff.

Open New Nurses' Home

A nurses' home, providing living quarters for 70 of the 175 student nurses now in training and classrooms, library and recreational facilities for all the students, was opened recently at the Little Company of Mary Hospital in Chicago.

Medical Group Urges States to Act Now on Voluntary Plans

A voluntary health insurance plan in every state was the objective sought by officers of state medical societies meeting at a conference in Chicago December 2, immediately preceding the meeting of the house of delegates of the American Medical Association.

The conference passed a resolution urging states to act quickly to establish prepayment programs. Another resolution approved the National Health Congress proposed in an article in The Modern Hospital as a means of speeding the organization and introduction of nationwide health coverage.

A. J. Altmeyer, chairman of the Social Security Board, told the group, which was formally assembled as the "first annual conference of presidents and other officers of state medical societies," that the medical profession needs the help of government to assure adequate health service for all the people. But, the conference replied in a series of resolutions adopted at the close of the program: "The function of government should be to encourage and assist, rather than compete with, voluntary health insurance plans."

The group also went on record as favoring a national secretary of public health and medical welfare in the President's cabinet, federal encouragement of scientific research for the improvement of medical care, and the formation of public health information bureaus in all states.

Dr. Joseph H. Howard, president of the Connecticut State Medical Society, stressed the fact that the conference was not opposed to the A.M.A. or critical of the A.M.A. program. "We are simply urging the A.M.A. to correlate the efforts of the various states in developing a health plan on a national basis," he declared.

50 Eastern Hospitals Work With Eye Bank

Fifty hospitals are now cooperating with the Eye Bank for Sight Restoration, Inc., an organization formed early this year to make healthy corneal tissue available for surgical transplantation to overcome blindness caused by corneal opacity. Affiliated hospitals aid in the eye bank's program for collecting, preserving and distributing the healthy corneas needed for this operation. These must be either taken from living persons or removed immediately after death, and they must be transplanted within seventy-two hours, since today's methods will not preserve them longer than that. Speedy, systematic exchange of information is thus essential; when eyes are available, the Red Cross Motor Corps rushes them to the eye bank for distribution to hospitals in which transplant operations may be scheduled.

Thirty-two of the cooperating hospitals are in New York City, eight are in New York State, six are in New Jersey and three are in Connecticut. In addition, a branch of the eye bank has been established at the Mayo Clinic. A cross-country network of cooperating hospitals, located at strategic centers, is the bank's goal.

Other objectives include the establishment of fellowships for teaching the corneal graft operation and for research in blindness caused by corneal disease. Eye bank officers estimate that 10,000 blinded Americans could have their sight restored by means of this operation.

Release Married Navy Nurses

Around 700 Navy nurses, 500 of whom are in the Naval Reserve, have been affected by the new order declaring married officers of the Navy Nurse Corps, Reserve and Regular, ineligible for retention in the service. Resignations for intention to marry, however, are not accepted. The present strength of the Nurse Corps is 10,874 with approximately 9100 in the Reserve.

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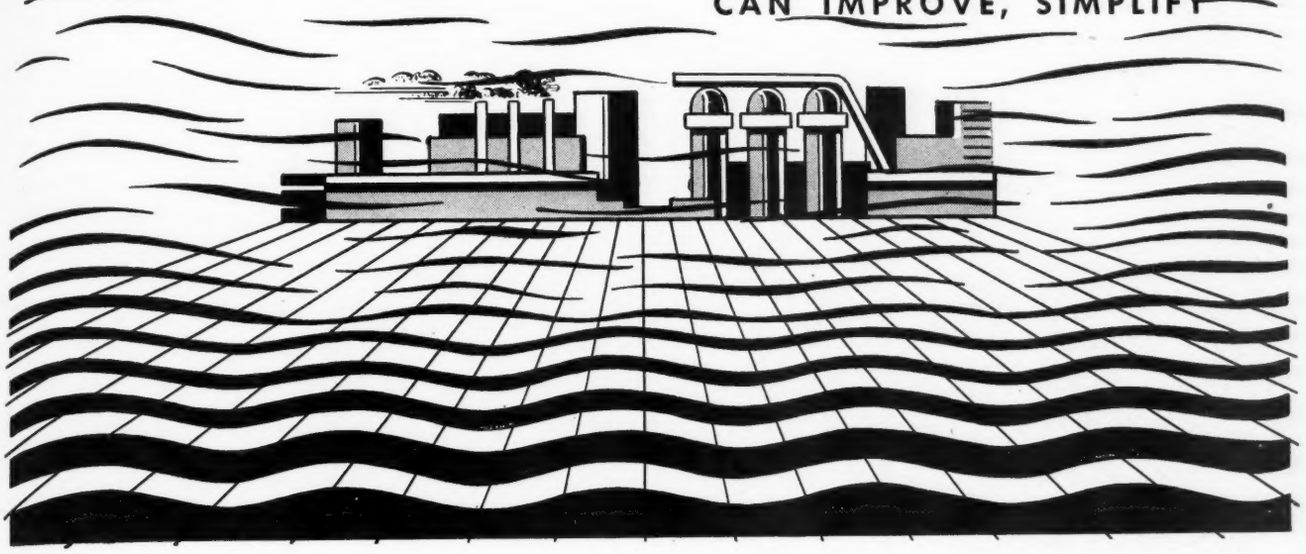

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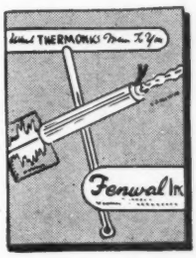

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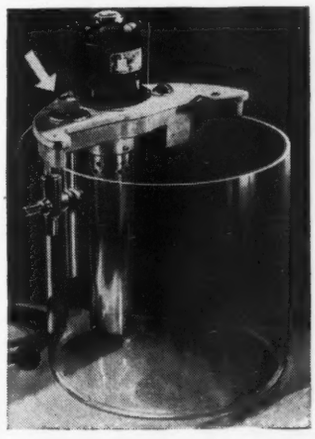

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Better Mental Health for Connecticut Is Governor's Plan

General hospitals in Connecticut may get state financial aid to develop psychiatric services, Gov. Raymond E. Baldwin said in an address outlining the statewide mental health plan recently approved by the state legislature.

"Our basic plan is one of prevention, designed to assist people early, so that they can be helped back to normal living before their cases require long hospitalization," the governor explained.

"Building hospitals and institutions is an expensive proposition," he continued. "It means money for construction, money for staffing buildings and money for caring for institutionalized cases. In Connecticut we are emphasizing preventive measures, at the same time keeping the facilities at our hospitals and mental institutions on a high standard."

Governor Baldwin then outlined the mental health plan for Connecticut which he recommended to the legislature. The plan authorizes state mental hospitals to establish psychiatric clinics for adults and permits state schools for the mentally defective to establish clinics for retarded persons and those suffering from epilepsy, it was explained. In addition, general hospitals may apply to the state department of health for financial aid in the development of their psychiatric services.

Officials Act to Meet Penicillin Shortage

WASHINGTON, D. C.—With the nation facing a shortage of penicillin, hospital officials in many cities are limiting use of the drug to urgent cases. Gallinger Hospital, Washington, D. C., received a directive several weeks ago putting penicillin on the restricted list.

Walter Reed General Hospital and the Naval Medical Center at Bethesda have not suffered any restrictions. An official in the chemicals division of Civilian Products Administration told the Washington correspondent of The MODERN HOSPITAL that hospitals should seek the aid of the chemicals division in case of emergency requirements.

So that hospital requirements for penicillin in all forms may be met to the fullest possible extent, C.P.A. officials and members of the Penicillin Producers Industry Advisory Committee have agreed that an order or directive should be issued giving hospitals first call on penicillin production. Although production dropped in September, it increased in October, according to C.P.A.

Study Careers of Women M.D.s

A study, undertaken to determine what use women graduates of seven representative eastern medical colleges have made of their training during the last twenty years, shows that of 1240 graduates, 82 per cent who married have remained in full-time medical work; 90 per cent were in full-time medical work during 1942-43. Florence de L. Lowther, Ph.D., associate professor of zoology, and Helen R. Downes, Ph.D., assistant professor of chemistry, both of Barnard College, New York, made the study which was reported in one of the recent issues of the *Journal of the American Medical Association*.

Britain Suffers Nurse Shortage

Britain has been forced to close a number of wards in general hospitals, sanatoriums and mental disease institutions owing to a severe shortage of nurses. There is immediate need for 33,000 or 34,000 more nurses, according to Aneurin Bevan, Minister of Health. Consequently, the government is going to make nursing a more attractive profession by increasing the weekly wage by $4 to $6 and improving living conditions. Pensions and four week paid vacations annually have already been provided.

Attendance at Fifth Maryland-D. C. Meeting Jumps 1000 Per Cent

An increase in attendance of almost 1000 per cent was recorded at the fifth annual meeting of the Maryland-District of Columbia Hospital Association at the Lord Baltimore Hotel in Baltimore on November 29 and 30. At the second annual meeting in 1942, there were only 55 registrants as compared with the nearly 600 at the latter session.

Dr. Merrell L. Stout, director of the Hospital for Women of Maryland, Baltimore, became president for the current year, and the following were elected:

President-elect, Dr. Edwin L. Crosby, first assistant director, Johns Hopkins Hospital, Baltimore; first vice president, J. G. Capossella, superintendent, Central Dispensary and Emergency Hospital, Washington; second vice president, Sister Mary Celeste, R.N., superintendent, Mercy Hospital, Baltimore; third vice president, Mattie Gibson, R.N., superintendent, Children's Hospital, Washington; treasurer, William A. Dawson, director, South Baltimore General Hospital; secretary, Richard R. Griffith, administrator, West Baltimore General Hospital.

Included on the program was a report by J. Douglas Colman, executive director of the Associated Hospital Service of Baltimore, Inc., who spoke for the committee named to study the possibilities of a central blood procurement agency which would serve all Maryland hospitals. Although plans are still tentative, Mr. Colman said that it was hoped such an agency could be established soon through cooperation of the Red Cross, the hospitals and the medical profession.

Plan Expansion of Lakewood Hospital

An extensive program which will provide for doubling the bed capacity of Lakewood Hospital, Lakewood, Ohio, reestablishing a school of nursing and building a nurses' dormitory, a chronic disease hospital and home for the aged has been approved by the hospital trustees of whom Mayor Amos I. Kauffman is chairman. An estimated expenditure of $3,500,000 will be required to make the hospital a medical center of the west side of Greater Cleveland.

Realization of the project calls for three steps which would spread the cost over a period of years and allow each unit to develop before proceeding to the next. The first and immediate step of doubling the bed capacity at a cost of approximately $1,500,000 is expected to be financed through a bond issue, according to Dr. R. B. Crawford, superintendent.

With occupancy having grown to a high of 94.6 per cent in June 1945, a need for more hospital beds in Lakewood has been established. The beds are filled consistently and the admitting office has a waiting list of from 200 to 300. A survey among physicians who use Lakewood Hospital regularly showed these physicians sent an average of 252 patients monthly to other Greater Cleveland hospitals because they could not obtain beds for them in Lakewood Hospital. The survey showed also that these physicians treated at home each month 237 patients whom they would have sent to Lakewood Hospital had there been room.

V.A. Consultants Named

WASHINGTON, D. C.—Thirteen medical consultants from the faculties of Northwestern and Illinois universities initiated November 23 the Veterans Administration's new program of cooperation between V.A. hospitals and established medical schools. The new consultants will be attached to the hospital at Hines, Ill. Such consultants are employed on a fee basis and a yearly contract, the compensation not to exceed $6000 per annum.

Protest Civil Service Policy of Recruiting Untrained Pharmacists

WASHINGTON, D. C.—The Civil Service Commission's policy of recruiting pharmacists who do not meet the legal standards of education and training for licensure in 45 of the 48 states was vigorously protested here by Dr. Robert P. Fischelis, secretary of the American Pharmaceutical Association, in telegrams sent to President Truman and to the president of the U. S. Civil Service Commission.

The U. S. Civil Service had issued in late October a circular advertising an examination for pharmacists in the government service. The requirements set forth permitted anyone with three years of practical experience, and with no college training, to qualify for the examination.

Doctor Fischelis requested the Civil Service Commission to withdraw from circulation its announcement, which, he said, invited unqualified persons to apply for positions as pharmacists in government service.

Duties of V.A. Hospital Administrator Defined

The duties of Lt. Col. Harry E. Brown, newly appointed administrative head of Veterans Administration hospitals for the entire country, were defined in a recent order by Lt. Gen. Omar Bradley, Veterans Administrator.

Colonel Brown will direct the hospital planning and operation service, which has been separated from the medical direction of veterans' hospitals. He will also select sites for additional hospitals and have charge of the acquisition of beds in civilian and Army and Navy hospitals for use by the Veterans Administration.

Before entering the Army, Colonel Brown was superintendent of Northwestern Hospital in Minneapolis for ten years.

Start Cleveland Building

Ground has been broken for the erection of the new main entrance and additions to the Cleveland Clinic Hospital, a project which is expected to cost around $2,750,000 when completed. The present hospital will be substantially remodeled, and it is estimated that the contemplated expansion program will provide space and facilities necessary for about ten years' growth, based on past experience. The Cleveland Clinic Foundation, which owns the hospital and clinic properties, is financing the building program. Architects are Ellerbe and Company of St. Paul.

Dressed Daily

Alcohol has several important applications peculiar to maternity and pediatric techniques. One of these is the daily dressing of alcohol applied to the tied-off umbilical cord of an infant from time of birth until the cord sloughs away.

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Relief Agency Sends Prosthetic Equipment to Soviet Union

The American Society for Russian Relief has sent its first shipments of materials for a detailed network of hospitals, a central factory and workshops to be established in the Soviet Union for the care of amputation cases caused by the war, according to Lewis V. Mays, bank administrator and chairman of the agency's Hospital Supplies Committee.

David Weingard, director of relief activities and who recently returned from the Soviet Union, says that amputation cases are so numerous in Russia that only a complete manufacturing setup producing artificial limbs on the spot could supply sufficient quantities to meet the current demand. He explains that the Soviet Union has no means other than Russian Relief for obtaining desperately needed medical aid and equipment.

Russian Relief estimates that the entire project will cost $1,000,000, funds for which will be raised through cash donations and "project adoptions" by organizations and individuals for specific items.

Chicago Gray Ladies Leave Civilian Hospitals to Aid Vets

To meet the rapidly growing need for their services in veterans' and military hospitals, Red Cross Gray Ladies are being withdrawn from assignments in the majority of Chicago civilian hospitals, according to an announcement by Mrs. Stuyvesant Peabody, chairman of the Hospital and Recreation Corps of the Chicago chapter.

By January 1, Mrs. Peabody declares, only five civilian hospitals in the Chicago area will have Gray Ladies service. These are Cook County, Children's Memorial, Provident, La Rabida Sanitarium and the University of Illinois Orthopedic Surgical Institute. In these institutions the special needs of patients, particularly the children, make continuation of Gray Ladies services important.

The action taken by the Chicago chapter was necessitated by increased responsibilities in veterans' and military hospitals and does not reflect a national policy. In each city the action taken is entirely optional, it was explained.

Plan for a Medical Center

A master plan for the proposed development by 1960 of a medical center on 35 acres of land centered around the present Duval County Hospital, Jacksonville, Fla., has been submitted to the county welfare board. The first developments on the list prepared by Reynolds, Smith and Hills, engineering firm retained to make the survey and draw up the plans, are the construction of a psychiatric unit, already provided for by a legislative act, nurses' home, interns' quarters, central service building, renovation of the present hospital and removal of the family welfare agency from the hospital to another building.

United Hospital Fund Nears Goal

Latest reports from the United Hospital Fund campaign in New York City show a total of $1,468,011.23 subscribed toward the total goal of $1,661,255.74. Evidence of the increasing base of support is revealed in the large numbers of individual contributors. Many smaller contributors of last year have increased their donations during the present campaign. The campaign closes January 1.

A.S.T.P. to Be Liquidated

Medical students now in the Army Specialized Training Program, which is undergoing gradual liquidation, will continue training through the current fiscal year ending June 30, 1946, with the future of the program depending on requirements for medical officers, which will be reconsidered at that time.

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Kansas Association Elects New Officers

Mrs. Zelma Smith, administrator of McPherson County Hospital, was named president of the Kansas Hospital Association for the coming year at the association's annual meeting in Topeka November 13 and 14. A feature of especial interest at this meeting was the discussion section for a group of hospital trustees, covering such subjects as care of chronic disease patients, Blue Cross, credits and collections and general administrative problems.

The trustee group also passed a resolution authorizing the association to cooperate with the Kansas Medical Society to develop a program providing gasoline tax funds to pay hospital and doctor bills for victims of highway accidents when no other means of payment are available.

Acting to implement the recommendation made at the American Hospital Association's house of delegates meeting at Chicago earlier in the month, the Kansas association urged on its members a program calling for hospitals to donate 1 per cent of their Blue Cross payments to a fund for advertising the advantages of Blue Cross membership in local newspapers.

In addition to Mrs. Smith, other officers elected by the association for the coming year were: first vice president, Zillah Leasure, Newman Memorial Hospital, Emporia; second vice president, Elmer Ahlstedt, Asbury Protestant Hospital, Salina, and secretary-treasurer, Matilda Papenhausen, Cushing Memorial Hospital, Leavenworth. Homer Gleckler was named as delegate to the American Hospital Association.

Lt. Cmdr. DeWitt Navy Nurse Head

WASHINGTON, D. C.—Lt. Cmdr. Nellie Jane DeWitt, Nurse Corps, U.S.N., has been appointed superintendent of the Navy Nurse Corps to succeed Capt. Sue S. Dauser, the Navy Department announced November 9. The new superintendent was graduated from Stamford Hospital Training School, Stamford, Conn., in 1918. She joined the Navy Nurse Corps shortly thereafter.

Captain Dauser is now on terminal leave pending retirement after twenty-eight years in the service. In World War I, she served as chief nurse of Naval Base Hospital No. 3 in Edinburgh, Scotland. Named Superintendent of the Nurse Corps in 1939, Captain Dauser supervised this branch of the Navy from a strength of 436 to a peak of 11,500 on V-J Day. Present strength of the Navy Nurse Corps, with demobilization steadily under way, is 10,000.

New Drug Aids Epileptics

Experiments with the use of tridione, a new synthetic drug, are reported successful in the treatment of epilepsy, according to Dr. Louis S. Goodman, head of the department of pharmacology at the University of Utah Medical School. Injections have proved effective in forestalling seizures of petit mal which is as serious as grand mal but not as well known the scientist explains. Although tridione cannot be bought on the market, Doctor Goodman says he is able to furnish limited amounts to practicing physicians for certain types of patients.

Grant Funds to Study V.D.

Funds to organize a research laboratory to study the effectiveness of penicillin as a curative agent in the treatment of experimental syphilis in human beings have been made available to New Britain General Hospital, New Britain, Conn., by the Office of Scientific Research and Development. Dr. Paul D. Rosahn, pathologist in charge of laboratories at the hospital, has been appointed investigator. The investigation is part of a cooperative study being directed in several large centers by a National Research Council subcommittee on venereal diseases.

Nebraska Hospital Association Meets

President-elect of the Nebraska Hospital Association for 1946 is Cecelia Meister, administrator of Bishop Clarkson Memorial Hospital at Omaha, who was elected during the association's annual meeting in Omaha November 19 and 20.

Interesting discussions presented during the meeting included the report of rural health education by Prof. H. C. Filley of the University of Nebraska, president of the board of trustees of Bryan Memorial Hospital in Lincoln, and a progress report of the Nebraska Surgical Plan presented by Dr. A. J. Offerman.

Everett W. Jones, vice president of The Modern Hospital Publishing Company, presented a talk on personnel and public relations.

Other officers elected by the association included secretary-treasurer, D. W. Duncan, St. Joseph's Hospital, Omaha; delegate to the American Hospital Association, Harold J. Hamilton of the Brewster Clinic at Holdrege. Trustees elected were: Sister M. Siegberta, St. Mary's Hospital, Columbus; D. P. Wetzel, Lutheran Hospital, Norfolk; Sister Mary Jane, St. Catherine Hospital, McCook, and Augusta Christiansen, Mary Lanning Memorial Hospital, Hastings.

End Fact-Gathering Phase of Michigan Study

Completed schedules of information have been received in the Chicago office of the Commission on Hospital Care from most of the Michigan hospitals participating in the state's fact-gathering phase of the hospital survey.

These schedules have been prepared for tabulation and were presented for discussion when the Michigan Hospital Survey Committee met with the commission's technical staff December 14. Eugene B. Elliott of the state department of education is chairman and Dr. William DeKleine, state commissioner of health, is vice chairman of the Michigan committee.

The technical staff of the commission presented the hospital data in relation to a study of socio-economic and geographic factors relating to hospital use and need to the Michigan committee for discussion.

Offers Course for Practical Nurses

On January 2 students will enter the first class in practical nursing in the school to be established at Leigh Memorial Hospital, Norfolk, Va. The course will be of a year's duration and students will receive instruction and be under the supervision of registered nurses.

Upon completion of the course, students will be eligible to take the examination for "licensed attendant" given by the Virginia State Board of Nurse Examiners.

Applicants must be between 18 and 40 and two years of high school is recommended but not required. An allowance of $15 per month, plus room, board and laundry, will be made to each student during the course.

Fungus Powder Successful

In a study involving more than 5600 Navy men at Fort Pierce, Vero Beach and Melbourne, Fla., field tests with undecylenic powder, a new powder for fungus infection, were reported successful by the research division of the Navy's Bureau of Medicine and Surgery. Active ingredients of the powder are undecylenic acid (2 per cent), a fatty acid found in sweat and its zinc salt, zinc undecylenate (20 per cent), which are mixed with ordinary talc. The ointment contains 5 per cent undecylenic acid and 18 per cent zinc undecylenate in a carbowax base, with water, propylene glycol and triethanolamine.

Army Releases 13,000 Doctors, 20,000 Nurses

The Army's quota of 13,000 doctors to be released to civilian life by December 31 has been exceeded six weeks in advance of the deadline, Maj. Gen. Norman T. Kirk, surgeon general, announced.

The total number of doctors who have been separated from the service reached 13,320 for the week ending November 16. For the same week the total for nurses who have been retired came to 20,222, and the total number of dentists was 2460.

Even though the December 31 quota has been attained sooner than expected, Medical Department officials pointed out there will be no slackening in the Army's efforts to return as many doctors as can possibly be released to civilian life in the quickest time.

From a peak strength of more than 45,000 doctors, General Kirk has announced that all but 11,000 will be out of the service by the first of June. In order to do this the Army must continue to follow its policy of expediting the release of doctors as well as other Medical Department personnel in every way possible.

Lohr Is President of Missouri Group

Dr. Curtis H. Lohr, administrator of the St. Louis County Hospital, was named president-elect of the Missouri Hospital Association at the annual meeting held in St. Louis November 15 and 16. Other officers are: first vice president, Edward A. Thompson, business manager of St. Joseph's Hospital, St. Joseph; second vice president, Bertha Hochuli, administrator, Boone County Hospital, Columbia. Rev. E. C. Hofins, administrator, Lutheran Hosiptal, St. Louis, was reelected treasurer. True Taylor of the Southeast Missouri Hospital, Cape Girardeau, was elected to the board of trustees, and Mrs. Irene McCabe of Missouri Blue Cross was reelected executive secretary of the association and delegate to the American Hospital Association. Hal Perrin, past president, is the alternate delegate.

Harry Mohler, president of the Missouri-Pacific Hospital Association and superintendent of the Missouri-Pacific Hospital, took over as president for the coming year.

Committee Will Study Air-Borne Diseases

The American Public Health Association has organized as a division of its Committee on Research and Standards a subcommittee for the evaluation of methods to control air-borne infections. Dr. James E. Perkins, director of the Division of Communicable Diseases, New York State Department of Health, is chairman of the subcommittee.

According to Doctor Perkins, the failure thus far to control air-borne infections, with the exception of those few diseases in which a means of active immunization has been developed, contrasts with the results from improvement in environmental sanitation as a result of purification of water supplies, proper disposal of sewage and sanitary production and pasteurization of milk. There are obvious advantages, Doctor Perkins explains, if the control of infections of the respiratory tract can be applied at the point of the mode of transmission rather than at the point of decreasing the susceptibility of the potential victim.

Prepare for Fight on Polio

WASHINGTON, D. C.—Local members of the National Infantile Paralysis Foundation have developed a program of full preparedness for any possible outbreak here of polio in 1946. A reserve of nursing assistance is being organized through a crew of polio emergency volunteers. A spring conference is planned with local health and hospital officials to investigate supplies and service before the actual need for them can arise.

New York Group Plans Public Relations Drive

Plans to establish a full-time office staffed with paid personnel for the purpose of telling the story of hospitals to the public were adopted at the November meeting of the Greater New York Hospital Association. The office is scheduled to open in January and to continue in operation for three years.

A yearly budget of from $15,000 to $20,000 was recommended, and it was said that other agencies would share the financial burden. It was pointed out, however, that the association would have the major responsibility for direction of the work of the public relations office.

In regard to the employment situation for which a counseling and placement service has been proposed, an annual budget of $30,000 or $35,000 was estimated. The meeting agreed, however, that first the nursing groups should back such a projected nursing placement service with financial aid and each hospital should contribute about $25 a month. The association would also assist financially if the various nursing districts will follow through on this stipulation.

Strikes Bar Service in New York Hospitals

Labor trouble disrupted service in another hospital in New York City when 164 maintenance workers walked out of New York Hospital as a result of a dispute between the hospital and the union as to whether the union should be recognized as representing a majority of the hospital workers.

Most seriously affected by the walkout were the power plant and elevators. The power plant was operated successfully, notwithstanding, by a skeleton crew of maintenance department heads who did not strike, while nurses, medical students and friends of the hospital operated the elevators. In the meanwhile, Israel Zion in Brooklyn, one of the four hospitals in Greater New York whose labor difficulties have been in process of adjustment over many months, agreed to negotiate with the union as to wages and hours, at the same time reserving the right to hire and to fire at its own discretion. Beth-El and Beth Moses hospitals are still seeking an equitable adjustment with union leaders.

Set Up Rehabilitation Clinic

A new rehabilitation clinic for veterans, to be known as the Veterans Rehabilitation Clinic of the Presbyterian Hospital, has been opened at Columbia-Presbyterian Medical Center, New York City. Its ultimate goal is to help the veteran to become an active, functioning member of the community. Types of neuropsychiatric problems will be treated in which a relatively short-term psychotherapeutic approach is required. A committee of laymen from all types of industry and business will assist in absorbing veterans into their organizations.

Nursery School Seeks Funds

An appropriation of $2,924,000 for 1946 has been requested of the county board by officials of the Cook County School of Nursing which supplies nursing service to Cook County Hospital. The nursing service is said to be inadequate and thus the increase in appropriation, $724,000 greater than that for the current year, was stipulated. An increase in the daily patient load from 2300 to 3300 is anticipated, resulting in a need for at least 176 additional nurses during the year. The hospital staff now has only 188 trained nurses.

Truman Lauds Pharmacists

President Truman paid high tribute to the pharmacy profession during the observance of National Pharmacy Week, November 4-10. In a letter to Dr. George A. Moulton, president of the American Pharmaceutical Association, Mr. Truman said, "The thousands of pharmacists who have served their country in the Army and the Navy and the additional thousands who have kept a careful watch on the health of the civilian communities have achieved a record which merits highest praise. My message . . . is to carry on with the same efficiency as we enter the era of reconstruction immediately ahead."

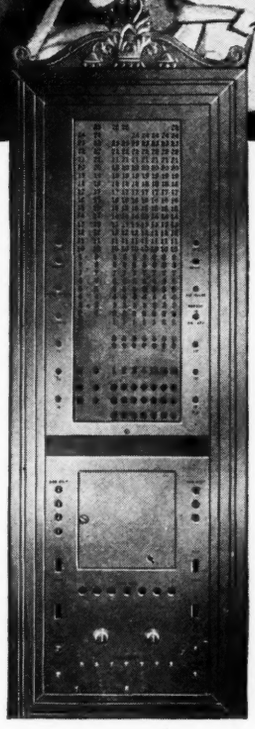
Curb Misuse of Drugs

As the first step in its program to curb misuse of barbiturates, the American Pharmaceutical Association called a conference of representatives of medicine, pharmacy, public health and government at its Headquarters Building in Washington. A. L. I. Winne, chairman of the committee on legislation, presided at the sessions at which every aspect of the problem was explored and commented on in detail by a group of experts in the field of medical and pharmaceutical practice, law enforcement and public health.

Issue Geriatrics Magazine

The first issue of *Geriatrics*, a new bi-monthly medical journal devoted to research and clinical reports on the processes and diseases of the aged and aging, will make its appearance in January, the publisher, Modern Medicine Publications, has announced.

OTIS *Dispatching* FOR IMPROVED ELEVATOR SERVICE



Dispatching Panel: Indicates position and direction of travel of the car and the location of waiting passengers.

Otis Elevator dispatching methods and equipment can help correct congested elevator traffic conditions.

This scientific system of elevator operation and dispatching provides the highest quality and maximum quantity of service for a given number of elevators.

Otis dispatching is your assurance that every car is doing an equal share —that the flow of traffic is evenly distributed over the entire plant.

So, when it comes to new elevator installations or getting more work from your present equipment, investigate the possibilities offered by Otis dispatching equipment.

Your Otis representative is ready now to help you and your Architect plan the correct type of dispatching system best suited to your needs. For the finest in vertical transportation tomorrow, call your Otis representative TODAY.

Otis ELEVATOR COMPANY
OFFICES IN ALL PRINCIPAL CITIES

ABOUT PEOPLE

(*Continued From Page 92*)

Hygiene in California. The first of its kind in California, the post was created by the 1945 legislature on the recommendation of **Mrs. Dora Shaw Heffner,** director.

Dr. John J. Bourke of Albany, N. Y., is director of New York's statewide survey of hospital facilities inaugurated in November for the State Joint Hospital Board. Doctor Bourke, formerly deputy director of the State Legislative Health Preparedness Commission, is now on terminal leave as commander in the U. S. Coast Guard after a year's service in the Pacific theater.

Lt. Col. Harold B. Hilton, assistant to the First Air Force Surgeon, has been selected executive officer for the Medical Section of the United States Strategic Bomb Survey Group in the Japanese home islands, a temporary detached service from his permanent assignment at Headquarters, First Air Force, Mitchel Field, N. Y. Lt. Col. Hilton is a graduate of the Medical Field Service School, Carlisle Barracks, Pa., School of Applied Tactics in Orlando, Fla., Hospital Operation course at Cornell University, New York, and the thirteenth Institute for Hospital Administrators at the University of Chicago.

Maj. Gen. George F. Lull, Deputy Surgeon General of the Army, was awarded the Distinguished Service Medal recently for "exceptionally meritorious conduct in the performance of outstanding services in the Office of the Surgeon General from June 1940 to August 1945." In addition to other duties, he has served as assistant to the Eighth Corps Area Surgeon, medical adviser of the Governor General of the Philippines and as director of military personnel and chief of the statistical division in the Office of the Surgeon General.

Brig. Gen. Hugh J. Morgan, director, Medical Consultants Division, and **Col. Francis R. Dieuaide,** chief of the Tropical Disease Treatment Branch, are inspecting medical services in the Pacific, Japan and Japanese territory and surveying problems concerned with internal medicine.

J. Solon Mordell is now chief of the Drugs and Pharmaceuticals Unit of the Medical Supply Section, U. S. Public Health Service, Office of Surplus Property Utilization. He was formerly chief pharmacist at University of Syracuse Hospital, Syracuse, N. Y., and later with W.P.B.

Capt. E. E. Salisbury, who recently returned from military service with the U. S. Army, has resumed his duties as executive director of the Chicago Hospital Council.

Dr. William M. Schmidt, of New York City, formerly medical director for the New York region of the Children's Bureau, U. S. Department of Labor, has gone to Europe where he will supervise the health and medical services of the Joint Distribution Committee.

Colonel Hugo Mella has been appointed acting executive officer of professional services for the Veterans Administration, General Hawley has announced. Colonel Mella, formerly assistant medical director in charge of postgraduate instruction and medical research, succeeds **Dr. C. M. Griffith.**

Deaths

Dr. John D. McLean, medical director of Rush Hospital for Consumptives, Philadelphia, died at the age of 75.

Writes History of A.N.C.

WASHINGTON, D. C.—Dorothy Sutherland, editor of *R.N.*, a journal for nurses, has been given the assignment of writing a history of the Army Nurse Corps in World War II.

SI-FLO
FLUSH VALVE
K-9000 BSP
(Patented)

Quiet

IN OPERATION . . . IT ONLY WHISPERS

The Speakman Si-Flo Flush Valve is ideal for hospital and institutional installations. It eliminates objectionable noises such as line noises, throttling noises, as well as closing noises and water hammer. ***ALL WEARING PARTS RENEWABLE*** . . . This is an important feature for institutions. In five minutes the complete piston assembly may be replaced and the unit is back in service. No special tools. No special experience required. ***LOW MAINTENANCE COST*** . . . Only one moving part. Piston unit replacement constitutes complete repair of valve. Self-cleaning by-pass. ***OTHER FEATURES*** . . . Adjustable connection between valve and stop means lower installation cost. Saves time. Saves labor.

ANYSTREAM SHOWER HEAD
(Patented)

S-2250. Self-cleaning. Needle, normal or flood spray by simple turn of handle. No other shower head like it.

SELF-CLOSING BASIN FAUCET S-4320

Patented self-metering faucet. Non-clogging by-pass. External volume adjustment.

SPEAKMAN

"The Best in Brass Since 1869"

SHOWERS AND FIXTURES

SPEAKMAN COMPANY, WILMINGTON 99, DELAWARE

OFFICIAL ORDERS
November 7 to December 13

Business Machines.—Effective November 7 the O.P.A. has authorized increased ceilings on the first month's rent for all used business machines except typewriters.

Construction Materials.—Effective November 15, a uniform ceiling price was established for water-repellent gypsum boards by the O.P.A.

Penicillin.—Direction 4 to Conservation Order M-300 was issued on November 23 by the Civilian Production Administration. This says in substance that supplies of penicillin are not adequate and that preference must be given to certain essential orders as follows: (1) Any order placed by a hospital (defined as "any hospital for the treatment of human beings located in the United States or its territories or possessions and the Veterans Administration and the U. S. Public Health Service, but does not include any Army or Navy hospital"), including orders previously placed but not filled on November 23, 1945; (2) any order certified for hospital use. No producer of penicillin need deliver on these preferred orders in any calendar month more than an amount equal to 40 per cent of his preceding month's production of penicil'in or 40 per cent of his estimated production for that calendar month, whichever is greater.

Price Controls.—Effective November 15, specific cents-per-pound ceiling prices were established for the first time on cut-up portions of turkey. No longer is there any control over the price of fresh citrus fruits, at least for the period from November 19 to January 13. The O.P.A. will watch this situation closely and immediately restore price control should inflationary price increases develop. Cherry and grape jams and jellies, also apple preserves and jellies and apple butter, all carry slightly increased prices effective November 28. The O.P.A. announces that this is the first time since 1943 that processors of fruit preserves and jams have been allowed to pass on any of their increased costs to the purchaser.

Additional metal items and some printing services and printed paper products, scientific instruments and laboratory apparatus and other goods are being suspended or exempted from price control, O.P.A. announced November 15. Among items in the new list are: loose-leaf binders and covers, indexing systems, textile machinery accessories and parts, unwashed and washed wiping cloths, additional scientific instruments and laboratory apparatus.

Rubber Goods.—Items, such as rubber flooring or mats, sponge rubber products and rubber-covered rolls, which have been almost wholly out of production since 1941, are now being produced. Industry-wide ceiling price increases have been extended, effective December 1, to mechanical rubber goods whose 1944 production was one half, or less, of their last representative period of peace-time production, if the reduced production was caused by government restrictions or from use of the manufacturing facilities for other war goods.

Storage Batteries.—Eight types have been declared surplus by the Signal Corps and approximately 85,000 of them are for sale by regional offices of the Reconstruction Finance Corporation. They range from 2 to 12 volts and may be used as an emergency source of power for lighting. Retail ceilings are lower than the actual cost of the equipment to the government. This Order 85 to Supplementary Order 94 became effective November 15.

Textiles.—Price increases at manufacturing level have been authorized for terry products, huck and crash towels, cotton bed and crib blankets and blanket-robe cloth. These increases will be reflected in the higher prices to be charged by institutional wholesalers, but the higher mill prices will not be permitted to affect the cost of living. Conservation Order M-328 was amended November 13 to provide for equable distribution of many scarce items among which are listed bedsheets, pillow cases, blankets, towels, diapers, face cloths and table "linens." Effective November 15, the adjustable pricing provisions in various cotton textile regulations have been brought into line with each other and with most other price regulations; thus, producers may include clauses to provide that after a ceiling price is increased, the higher price may be charged for all goods yet to be delivered under the contract.

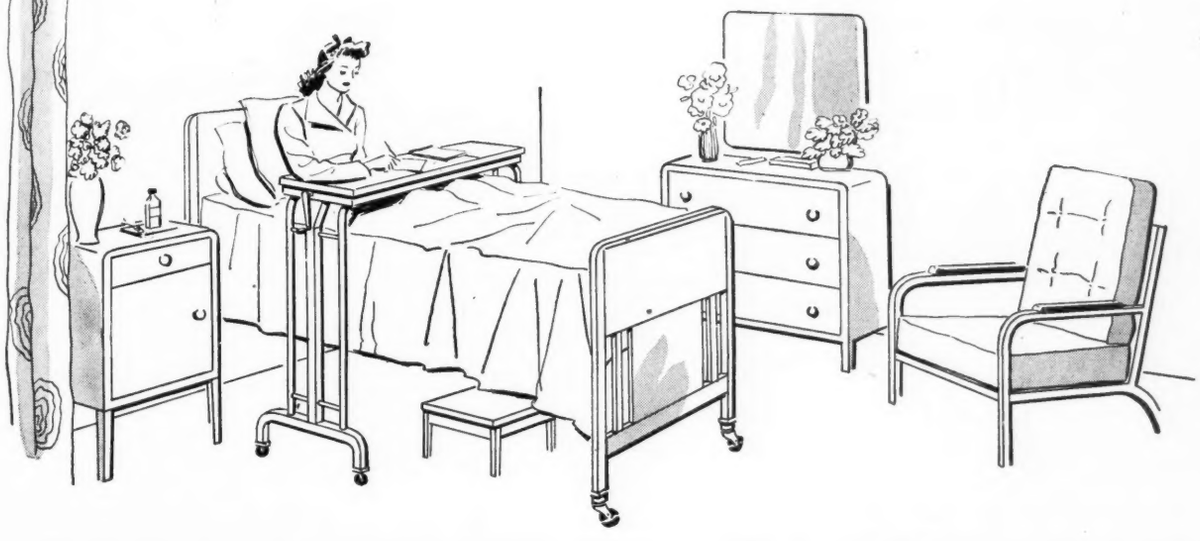
A.N.A. Leaflet Welcomes Returning Service Nurses

With the expected release of 25,000 Army nurses by January 1 and 2000 Navy nurses by February, the American Nurses' Association has taken steps to speed their return to civilian practice.

"W for Welcome," a compilation of information on such questions as renewal of state registration, advanced courses of study, job opportunities and addresses of state and national nursing organizations, has been issued by the Nursing Information Bureau of the A.N.A. as the result of inquiries from nurses already released from service.

The leaflets are being distributed to nurses at Army Separation Centers, Navy Personnel Separation Units, the New York Port of Embarkation and Red Cross hospitality and information centers through the cooperation of the American Red Cross Nursing Service and of the Army and Navy Nurse Corps. They can be obtained also through state and local nursing organizations.

You get GREATER WEAR RESISTANCE



in METAL Furniture...by Simmons

Here is *double protection* against the wear and tear of time, climate and hard use. First, there is the inherent strength and durability of metal. And second, there is the added protection of the exclusive "Simfast" finish. This tough, long-lasting finish does not mar, chip, crack or peel. It is weather resistant, and impervious to the action of most medicinal preparations. Thus, the beauty and serviceability of Simmons furniture and sleep equipment are safeguarded year in, year out.

Follow the example of leading hospitals and institutions everywhere. Standardize now on Simmons METAL furniture and sleep equipment! See your Hospital Supply Dealer for full information.

SIMMONS COMPANY

HOSPITAL DIVISION

DISPLAY ROOMS

CHICAGO 54—Merchandise Mart • NEW YORK 17—383 Madison Avenue
SAN FRANCISCO 11—295 Bay Street • ATLANTA—353 Jones Avenue, N.W.

THE BOOKSHELF

THE JAMAICA HOSPITAL, *A History of the Institution,* 1892-1942. *Written and compiled by F. G. Riley, M.D., Historian of the Medical Board of the Jamaica Hospital. Published by the Medical Board of the Jamaica Hospital. Pp.* xv—172. 1943.

With rare skill, Doctor Riley gives the historical and social setting of the time and place in which physicians and other citizens of Jamaica, and particularly the King's Daughters, worked together to found a hospital in that Long Island suburb of New York City.

Jamaica Hospital began its service in a converted dwelling-house, for which the King's Daughters paid a monthly rental of $15. It occupied its first permament building in June 1898. However, this plant was not fully ready for occupancy when thousands of sick and wounded soldiers of the Spanish-American War began arriving at Camp Wykoff at Montauk Point. The trustees patriotically decided to make the institution's facilities available for some of them, as their needs seemed more pressing than those of the local civilians.

The third and present home of the Jamaica Hospital was opened in August 1924. From the beginning this hospital has been a community enterprise in which citizens of all creeds and walks of life have shared in both its support and its service.

A part of this profusely illustrated book consists of biographical sketches of members of the hospital's medical staff and board of trustees.—JOHN E. RANSOM.

MEN UNDER STRESS. *By Lt. Col. Roy R. Grinker, U.S.M.C., and Maj. John P. Spiegel, U.S.M.C. Philadelphia: Blakiston Company.* 1945. *Pp. xii*—484. $5.

Man's behavior in situations of wartime stress has been the subject of manifold description since our entrance into World War II. The chronicles of Colonel Grinker and Major Spiegel comprise a noteworthy contribution to the annals of war-time psychological medicine. They have published a series of interesting observations on combat reactions, the first of which was the excellent monograph "War Neuroses in North Africa," a study of the psychologically wounded among the ground force soldiers. The high standard of their previous studies has continued in their present volume "Men Under Stress," relating to psychological disturbances arising among air forces personnel.

This book deals with men in active combat and casualties in an Army Air Forces convalescent hospital in this country. The first part is devoted to the background and selection of men in the Air Corps. The motivations which underlie the attractions for flying are discussed. This is followed by an analysis of the environment of combat and the importance of the combat team as a unit in keeping psychiatric casualties to a minimum. The authors have had the opportunity to survey a wealth of clinical material covering several thousand cases from which 65 cases have been selected to illustrate the problems discussed.

The reactions to combat are examined from several points of view; the authors, however, elaborate upon only two groups of psychiatric casualties developing on the basis of external stress. In the first group the stress has been minimal and yet has produced severe symptoms. In the second instance the stress has been severe and has produced symptoms only after prolonged exposure. A most important factor appears to be the psychological preparedness of the individual to react to specific stimuli which may be encountered. The authors theorize that the failures of adaptation underlying the signs and symptoms of neurotic combat

reaction can be explained in terms of dynamic disturbance of the ego structure or in terms of cortico-diencephalic interrelations.

Several chapters are devoted to the treatment of war neuroses with a detailed description of the technics of psychotherapy, narcosynthesis and an evaluation of other pharmacological measures employed for therapeutic purposes. Because of the pressure of time and numbers the authors have had to devise technics and therapeutic measures from which psychiatrists may acquire helpful suggestion in the management of their problems of short-term therapy.—SEYMOUR D. VESTERMARK, M.D.

CAMPING FOR CRIPPLED CHILDREN. *Harry H. Howett, editor. Elyria, Ohio: The National Society for Crippled Children and Adults, Inc.* 1945. *Pp. xx*—120.

Any group planning to inaugurate a camping program for crippled children will find in this book a wealth of valuable material assembled under the direction of the Committee on Camping of the National Society for Crippled Children and Adults, Inc. All major points, from organization and construction through the complete camp program, are well covered by Mr. Howett. Detailed lists of necessary equipment and supplies and sample forms are shown. Although this guide is intended for use in meeting those situations peculiar to the crippled child, all camps could be improved if the standards outlined here were more nearly attained.

Regarding double deck beds, which would seem to be excusable as a necessary evil only in a Pullman car, Mr. Howett states that the folly of their use for handicapped children is self-evident. He prefaces this comment with "The United States Public Health Service . . . strongly condemns the use of double deck beds." Camps have not been the only offenders in this respect.

While a decidedly ideal program is presented, it is thoroughly practical with nothing unreasonable in the plan. There is everything one would look for in selecting a camp for one's own child; the same yardstick should be used for camps for other children.—MABEL W. BINNER.

EMPLOYEE COUNSELING. *By Nathaniel Cantor. New York: McGraw-Hill Book Company, Inc.* 1945. *Pp.* 157. $2.

This book offers a new approach of industrial psychology in reaching the real causes of employe dissatisfaction through employe counseling.

The book is written in clear, nontechnical language in typically "sociology" style. Emphasis is placed on the fact that an employe is a human being with feelings, emotions and attitudes and that he should be recognized and treated as a human being. Effective employe cooperation depends upon understanding these complexities of human personalities.

The author outlines the qualities and skills necessary for a trained consultant to help the employe bring to the open and clarify in his own mind the underlying emotional problems that may be troubling him and thus marring his efficiency on the job.

Examples of typical cases are presented to bring out various elements in the interviewing process. Although a great deal of space is devoted to these illustrations, the most important factor is that always it is the employe's problems and feelings that are kept at the center of the interview—not the counselor's.

The book is based primarily on industrial activities in technological production. Human beings, however, are the same regardless of the type of work in which they are engaged; therefore, the book offers a worth-while approach for all supervisors and foremen to try to develop a better understanding of the emotional and social problems influencing the efficiency of the worker.—IDA B. STRICK.

A WORD TO THE WISE

If you need *chromium furniture* today . . . here's a friendly suggestion. *It's wise to buy it only on the basis of the manufacturer's proved reputation.*

You see, chromium chairs and tables all look pretty much alike *when new,* and since there's no "better chromium bureau" to do the coaching . . . you can be *sure* of quality and steer clear of "orphan" merchandise only by relying on *names you know about.*

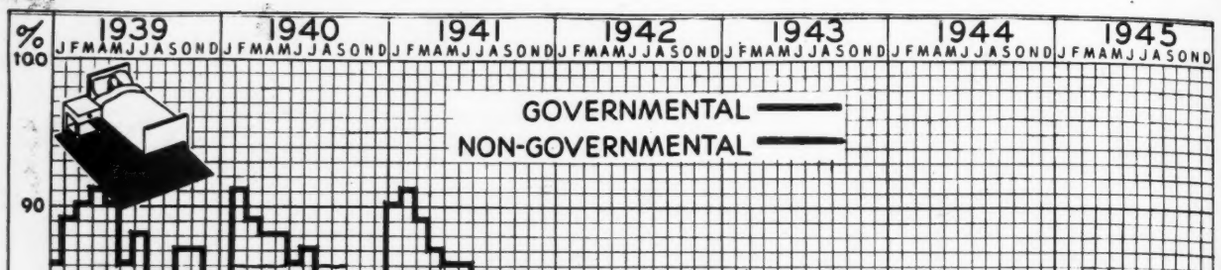
Royalchrome, for example, and similar high quality products of other reputable manufacturers will be increasingly more available in the weeks and months to come. *And it's worth the wait.* The Royal Metal Mfg. Co., 175 N. Michigan Avenue, Chicago 1, Illinois.

The Royal LINE OF TOMORROW

Metal Furniture Line '97

Royal Steel Folding Chairs • Royalchrome DISTINCTIVE FURNITURE • *Steel Furniture*

Occupancy Rises in Voluntary Hospitals



Occupancy in nongovernmental hospitals climbed to 82 per cent in October, early reports indicate, with occupancy of the governmental hospitals reporting remaining stationary for the third straight month at 68 per cent.

The number of hospital construction projects reported for the period rose again—this time to 57, as against 54 for the previous period and 40 for the one before that. Total cost of 48 projects reporting costs was $22,619,589, bringing the total of hospital construction costs reported for the first eleven months of the year to $248,780,265, compared with $103,192,000 last year.

Twenty-three of the 48 projects reporting costs were hospitals, with $12,687,000 in volume; 20 projects totaling $10,038,289 were additions; three nurses' homes added $740,000.

What's New for Hospitals

DECEMBER 1945 SUPPLEMENT TO THE MODERN HOSPITAL

Drug Service Trucks

Distribution of sterile goods, drugs and other supplies from the drug room, pharmacy or central supply to the wards and operating rooms can be facilitated by the use of the new drug service trucks recently announced. Available in two sizes, these trucks are designed to hold baskets or other carriers into which the drugs or other materials covering each requisition have been placed.

The small size truck holds two standard baskets on each of its two shelves which measure 27 by 30 inches inside and have an upturned 1½ inch edge on three sides. The large truck holds three standard baskets on each of its two shelves which are 26 by 51 inches in size with a band iron ledge 3 inches above the shelf on either three sides or all four. Both sizes are equipped with rubber tired casters with ball bearing wheels. **Jarvis & Jarvis, Inc., Dept. MH, Palmer, Mass. (Key No. 2887)**

X-Ray Therapy Field Blockers

A new set of synthetic rubber x-ray therapy field blockers has been developed for use as shields in practically any type of radiation equipment. Furnished in sections of varied sizes and shapes, the blockers are available in 1/16 and 3/16 inch thickness. The first at 100 kvp has 2 per cent transmission and a pure lead equivalent of 0.5 mm. The latter at 140 kvp has 0.5 per cent transmission and a pure lead equivalent of 1.5 mm. Each set consists of six pieces cut from an 18 by 18 inch sheet, three with approximately a 10½ inch circle and three with approximately a 7⅞ inch square. **General Electric X-Ray Corp., Dept. MH, 175 W. Jackson Blvd., Chicago 4. (Key No. 2869)**

Aluminum Tray

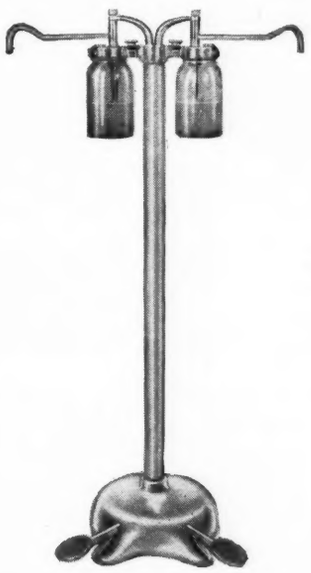
The Reynolds aluminum cafeteria tray manufactured to Navy specifications is now available in unlimited quantity for civilian use. The tray is made from 16 gauge, cold-rolled, extra hard sheet aluminum tightly beaded over heavy steel wire. The tray has the natural metal finish and is 13⅞ by 17¾ inches in size with a lip ⅞ inches deep. **Reynolds Metal Co., Dept. MH, 2564 S. Third St., Louisville 1, Ky. (Key No. 2876)**

Structural Glass

Carrara structural glass is now available in a new gray-green color known as Tranquil Green. It can be used for various structural purposes such as bathroom walls, table tops and similar uses and is announced as especially suitable for the walls of hospital operating rooms. **Pittsburgh Plate Glass Co., Dept. MH, 632 Duquesne Way, Pittsburgh 19, Pa. (Key No. 2879)**

Portable Dispensers

The postwar models of the Levernier Portable Foot-Pedal Soap and Alcohol



Dispensers, distributed exclusively by the Levernier Laboratories, offer a number of changes.

Among the changes in material, plastic is used for the pump pistons, thus simplifying construction and assuring long life of the unit and its parts. The soap container, holding one quart of soap, hangs from a supporting member above and is so arranged that operation is simple and foolproof and there is no possibility of leakage. The small number of movable parts are durable and strong.

The glass bowl, pump and parts coming in contact with soap are easily removed without tools for cleaning and sterilizing. Entirely chrome plated, the dispenser provides an attractive piece of equipment which serves a vital purpose in scrubup rooms. **Levernier Laboratories, Dept. MH, Syracuse, Ind. (Key No. 2915)**

Lime Scale Control

Slime growth and formation of lime scale deposits in evaporative condensers and evaporative coolers can now be controlled through the use of a new chemical development with lime solubilizing, fungistatic and detergent properties.

A small amount of the new product, a completely soluble, odorless, nontoxic, white powder, is designed to keep water sweet, prevent slime and hard lime scale from forming on coils, keep equipment clean and reduce maintenance. **Oakite Products, Inc., Dept. MH, 18A Thames St., New York 6. (Key No. 2832)**

Fluorescent Luminaire

The Jefferson is the name of a new fluorescent luminaire, Number A-1240, recently developed by the Pittsburgh Reflector Company. Light distribution is controlled by a reflector which is easily moved for access to the wiring channel. All metal parts are die formed assuring precision fit. The glass panels are accessible for maintenance without removal from the unit but can be instantly removed if desired. The fixture is available for either ceiling or pendant mounting. **Pittsburgh Reflector Co., Dept. MH, Oliver Bldg., Pittsburgh 22, Pa. (Key No. 2784)**

Inventory Record Control

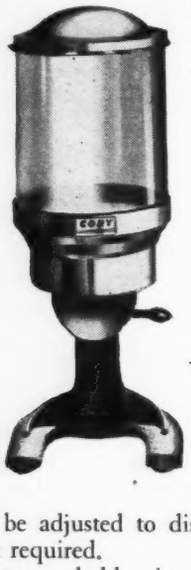
The Graph-A-Matic Computing Chart is a device which directly converts actual and available inventory quantities into the time it will take to consume them. The Graph-A-Matic Control Signal is set and provides the automatic conversion to supply and condition of stock. Inventory record keeping is simplified, clerical time is saved and stocks are kept up through the use of this device. **Systems Div., Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 2837)**

Cory Coffee Dispenser

Accurate dispensing of the exact amount of coffee needed for each unit of beverage made in the Cory Glass Coffee Brewer is now possible through the new Cory Coffee Dispenser. Uniform coffee

Address manufacturers for further information and prices—or use Readers' Service blank on page 256

flavor and quality and the avoidance of waste are the advantages of this unit



which can be adjusted to dispense just the amount required.

The dispenser holds six pounds of coffee in a glass container so that the amount of coffee still available is seen at a glance. The counter stand is attractively designed and the simple mechanical measuring device provides trouble-free operation. **Cory Glass Coffee Brewer Co., Dept. MH, 221 N. La Salle St., Chicago 7. (Key No. 2880)**

Civilian Aerosol Bomb

An improved civilian model of the aerosol bomb for fighting insects has been developed and is offered under the name Aer-A-Sol. The bomb contains one pound of 3 per cent DDT insecticide with pyrethrum and compressed liquid freon. A valve at the upper end releases the insecticide in a non-inflammable fog-like mist which remains suspended in the air from 20 minutes to two hours in an invisible form. The product is effective against most common insects and only a small quantity is required ranging from six to eight seconds of spraying for mosquitos and flies to thirty to sixty seconds for moths, roaches and similar insects. **Bridgeport Brass Co., Dept. MH, 30 Grand St., Bridgeport 2, Conn. (Key No. 2872)**

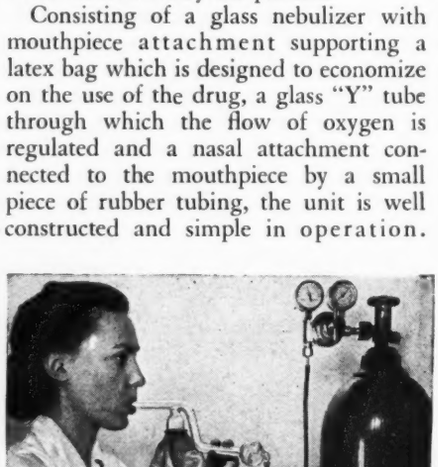
Skin Protector

Chemiglov is the name of a special skin protective cream developed for laboratory technicians and other workers. When spread in a thin film over the skin it forms an invisible protective layer on the hands and arms providing a barrier between the skin and chemicals or other solutions that might be harmful. Application is simple and the cream prevents staining or irritation of the skin. It is water repellent but is easily removed with soap and warm water. **Eimer & Amend, Inc., Dept. MH, 633 Greenwich St., New York 14. (Key No. 2776)**

Aerosol Nebulizer

The O.E.M. Aerosol Nebulizer has been developed for the administration of penicillin by inhalation in the treatment of infections of the upper respiratory system. Oxygen is the nebulizing force used and produces a fine mist of the drug which is inhaled by the patient.

Consisting of a glass nebulizer with mouthpiece attachment supporting a latex bag which is designed to economize on the use of the drug, a glass "Y" tube through which the flow of oxygen is regulated and a nasal attachment connected to the mouthpiece by a small piece of rubber tubing, the unit is well constructed and simple in operation.



Oxygen Equipment Mfg. Co., Dept. MH, 405 E. 62nd Street, New York 21. (Key No. 2890)

Boiler Maintenance

A new product for the maintenance of the inside brickwork of boilers has been announced under the name Zircoat-M. Containing a zirconium silicate base, this refractory is applied with a spray gun and forms a hard working surface that will withstand high furnace operating temperatures. Zircoat-M is shipped dry and mixed with water for spraying. **Basic Refractories, Inc., Dept. MH, 845 Hanna Bldg., Cleveland, Ohio. (Key No. 2833)**

Light Reflector

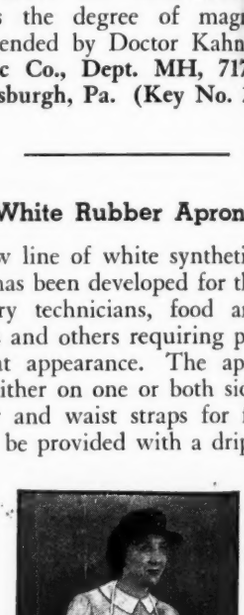
A new principle of light reflection is used in the Diamond Facet Reflector which has a surface broken into multiple diamond shapes. When used in flashlights, spotlights and similar equipment the reflector produces a clear white beam of light. The new Floodbeem Flashlight which has just been announced employs this principle of light reflection. **General Detroit Corp., Dept. MH, 2270 E. Jefferson Ave., Detroit 7, Mich. (Key No. 2834)**

Improved Kahn Viewer

An improved method of illuminating Kahn tubes containing test material and a low power magnifier through which the tubes are viewed are the principle advantages of the new Kahn Viewer. The illuminating system with white frosted lamp is contained in the base which is six inches square and three inches high. A removable glass plate on top of the base provides space for resting the Kahn tubes for observation. The tubes are illuminated by a ribbon shaped beam of light of adequate intensity and the observer views them against an adjacent dark field. A magnifying lens three inches above the observation surface provides the degree of magnification recommended by Doctor Kahn. **Fisher Scientific Co., Dept. MH, 717 Forbes St., Pittsburgh, Pa. (Key No. 2826)**

White Rubber Aprons

A new line of white synthetic rubber aprons has been developed for the use of laboratory technicians, food and drug handlers and others requiring protection and neat appearance. The aprons are coated either on one or both sides, have shoulder and waist straps for fastening and can be provided with a drip pocket.



Industrial Products Co., Dept. MH, 2820 N. Fourth St., Philadelphia 33, Pa. (Key No. 2871)

Address manufacturers for further information and prices—or use Readers' Service blank on page 256

PHARMACEUTICALS

Oral Penicillin Tablet

Per-Os-Cillin is the name of a new oral penicillin tablet developed by Hoffmann-La Roche. The product is stable and retains its potency for a long period. Special long-acting buffers to inhibit the destructive action of gastric acid upon penicillin are included and the tablets are designed to create a therapeutically effective blood level of the drug in approximately 30 minutes after administration. Each tablet contains 25,000 units of penicillin calcium. **Hoffmann-La Roche, Inc., Dept. MH, Nutley, N. J. (Key No. 2895)**

Pulvules Bilron

Developed for oral bile-salt therapy of liver and gall-bladder disease, Pulvules Bilron contain natural conjugated bile acids, purified and combined with iron to form iron bile salts. Being acid-insoluble, Bilron does not cause gastric irritation but dissolves readily at the optimum point for emulsification and absorption of food in the alkaline content of the intestine. Pulvules Bilron are supplied in 5 grain capsules in bottles of 100 and 500. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 2841)**

Conestron

Natural conjugated estrogens are contained in Conestron Tablets which have been developed to provide effective oral therapy for the menopausal patient. The tablets are highly potent and essentially safe, assuring the patient's sense of well being. Conestron Tablets are available in bottles of 100 and 1000, each tablet containing 0.625 mg. Estrone Sulfate. **Wyeth Inc., Dept. MH, 1600 Arch St., Philadelphia 3, Pa. (Key No. 2802)**

Penicillin Specialties

Squibb has announced the release of four new penicillin products. Tablets Penicillin Calcium (Buffered) each contain 20,000 units of penicillin calcium with 0.5 gram trisodium citrate as a buffer and are sealed in aluminum foil to protect against loss of potency. The tablets are supplied in boxes of 25.

Topicillin Chewing Troches contain 20,000 units of penicillin calcium each in a flavored, tinted paraffin base. These troches are designed to provide a high salivary content of the drug that lasts for several hours. They are available in boxes of 6.

Topicillin Ointment and Topicillin Ointment Ophthalmic contain 1000 units of penicillin calcium per gram in a stable ointment base. The ointment is supplied in tubes containing 14.5 grams and the ophthalmic ointment in tubes of 3.6 grams. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 2893)**

Camollient Cream

A water miscible vanishing cream base containing calamine, zinc oxide and camphor-phenol has been developed as a protective, analgesic, antiseptic and antipruritic cream for use in sunburn and other skin irritations. Known as Camollient Cream, the product is supplied in 1½ ounce tubes in cartons of 12. **Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 2750)**

Soluble Vitamin K

The official U.S.P. soluble form of vitamin K for injection, Menadione Sodium Bisulfite, is now being produced by William H. Rorer, Inc. Administered intramuscularly, this preparation produces a rapid rise in plasma prothrombin. It is a stable, colorless, sterile, aqueous solution ready for immediate injection and is supplied in 10 cc. serum capped vial. **William H. Rorer, Inc., Dept. MH, Philadelphia 6, Pa. (Key No. 2804)**

Sulfathiazole-Phemerol Cream

Sulfathiazole-Phemerol Cream is intended for local application in treatment of pyogenic dermatoses and other conditions complicated by secondary infections, such as infected eczema, acne vulgaris, furuncolosis, impetigo, seborrheic dermatitis and superficial skin infections. It is a smooth preparation consisting of microcrystalline sulfathiazole 5 per cent and phemerol 1-500 in a water soluble, nongreasy base. The cream is supplied in 1 ounce collapsible tubes. **Parke, Davis & Co., Dept. MH, Detroit 32, Mich. (Key No. 2839)**

Podophyllin Ointment

Podophyllin Ointment, 25 per cent, has been developed as an efficacious treatment of condyloma acuminata and granuloma inguinale. Containing 25 per cent podophyllin in an ointment base, the product is supplied in 1 ounce tubes to facilitate individual treatment and minimize the danger of cross infection. The pharmacist will be relieved also of the necessity of filling podophyllin prescriptions and the possibility of eye irritation which sometimes results. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 2892)**

RECENT CATALOGS AND BOOKLETS

• Serving the double purpose of textbook and catalog is a booklet issued by the American Sterilizer Co., Erie, Pa., illustrating and describing the posturing and "setting-up" of patients for all types of surgical procedures. Surgeons, anesthetists and operating room supervisors were consulted on correct posture and their advices incorporated in the material. The actual photographs used throughout should prove interesting and helpful to the surgical team. Full detailed information on **"American Surgical Operating Tables"** is included. **(Key No. 2901)**

• A discussion of **"Refrigeration and Air Conditioning in Hospitals"** by Terry Mitchell, M.E., is available in Bulletin 502 issued by Frick Co., Waynesboro, Pa. **(Key No. 2853)**

• **"Working With Newspapers"** is the title of a booklet prepared by the National Publicity Council, 130 E. 22nd St., New York 10. Written by Gertrude W. Simpson, the booklet should provide invaluable material for the hospital administrator and those of his staff concerned with public relations. Chapter headings such as "How Do You Know It's News," and "How to Get and Hold the Reader's Interest," "Take a Look at Yourself," and "Establish Your Agency as a Reliable Source of Information" will indicate the helpful type of material in this booklet for which the Council charges 75 cents per copy. **(Key No. 2907)**

• **"Guide to 'Full Color' Hearing"** is the title of a booklet containing illuminating information on the ear, the degrees of hearing loss, new possibilities with hearing aid developments and complete details of the construction and operation of the Model 63 Western Electric Hearing Aid. The booklet is available from Western Electric Co., Inc., 195 Broadway, New York 7. **(Key No. 2855)**

• The results of studies in the laboratories of Troy Research on **"Soil Removal"** are presented in **Research Bulletin YR-2** issued by Troy Laundry Machinery Div., American Machine and Metals, Inc., East Moline, Ill. Details cover the various types of soil and stains found in soiled linen and clothing with recommended methods for their removal. **(Key No. 2858)**

• **"Caterpillar" Diesel Electric Sets,** which should have application in hospitals for emergency lighting, are discussed in a booklet known as Form 9091 issued by the Caterpillar Tractor Co., Peoria 8, Ill. **(Key No. 2908)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 256

• Information on their various **penicillin products** is available from Cutter Laboratories, Berkeley 1, Calif. A file card containing directions, dosage and indications on Pen-Troches-Cutter has been prepared for the use of physicians and details of dosage and administration of Penicillin in Oil and Wax are discussed in a descriptive folder. **(Key No. 2911)**

• Eight advantages offered by the use of asphalt tile flooring are enumerated in a bulletin issued by the **Asphalt Tile Institute,** 19 W. 44th St., New York 18. **(Key No. 2905)**

• The use of Semdac Liquid Gloss for floor maintenance as a means to **"Reduce Infections Caused by Air-Borne Bacteria"** is the subject of a folder issued by Standard Oil Co. of Indiana, 910 S. Michigan Ave., Chicago 80. **(Key No. 2852)**

• **"The Basic Nutritive Values of Cake"** is the title of a bulletin prepared by Standard Brands, Inc., Fleischmann Div., 595 Madison Ave., New York 22. Containing information of interest to anyone concerned with nutrition, the booklet is one of a series on Progress in Nutrition. **(Key No. 2851)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 2750 Camollient Cream
- ☐ 2776 Skin Protector
- ☐ 2784 Fluorescent Luminaire
- ☐ 2802 Conestron
- ☐ 2804 Soluble Vitamin K
- ☐ 2810 "Melamine"
- ☐ 2812 Floorlife Cleaner
- ☐ 2813 "Deming Pumps"
- ☐ 2819 Red Star Fire Extinguisher
- ☐ 2821 Rockote Sparkproof Plastic Flooring
- ☐ 2822 Hornlume
- ☐ 2826 Improved Kahn Viewer
- ☐ 2832 Lime Scale Control
- ☐ 2833 Boiler Maintenance
- ☐ 2834 Light Reflector
- ☐ 2837 Inventory Record Control
- ☐ 2839 Sulfathiazole-Phemerol Cream
- ☐ 2841 Pulvules Bilron
- ☐ 2844 "Movies Go to Work"
- ☐ 2846 Thesaurus Library
- ☐ 2851 "Basic Nutritive Values of Cake"
- ☐ 2852 "Reduce Infections"
- ☐ 2853 "Refrigeration and Air Conditioning"
- ☐ 2855 "Guide to Hearing"
- ☐ 2858 "Soil Removal"
- ☐ 2869 X-Ray Therapy Field Blockers
- ☐ 2871 White Rubber Aprons
- ☐ 2872 Civilian Aerosol Bomb
- ☐ 2876 Aluminum Tray
- ☐ 2879 Structural Glass
- ☐ 2880 Cory Coffee Dispenser
- ☐ 2887 Drug Service Trucks
- ☐ 2890 Aerosol Nebulizer
- ☐ 2892 Podophyllin Ointment
- ☐ 2893 Penicillin Specialties
- ☐ 2895 Oral Penicillin Tablet
- ☐ 2901 "American Surgical Operating Tables"
- ☐ 2905 Asphalt Tile Flooring
- ☐ 2907 "Working With Newspapers"
- ☐ 2908 Diesel Electric Sets
- ☐ 2911 Penicillin Products
- ☐ 2915 Portable Dispensers

I would also like to have information on the following products

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

• Hospitals interested in making motion pictures for public relations and educational activities will want a copy of a booklet recently published by Bell & Howell Co., 7100 McCormick Rd., Chicago 45. Entitled **"Movies Go to Work,"** the booklet is designed for industry but offers many ideas for the hospital administrator and his public relations director, education committee and medical staff. **(Key No. 2844)**

• Information on the availability and performance of the 2½ gallon soda acid **Red Star Fire Extinguisher** is provided in a folder issued by the General Detroit Corp., 2270 E. Jefferson Ave., Detroit 7, Mich. **(Key No. 2819)**

• Hospital executives and department heads who like to keep abreast of the developments in the chemical and scientific fields will find interest in the 24 page illustrated booklet on **"Melamine"** issued by the American Cyanamid Co., 30 Rockefeller Plaza, New York 20. **(Key No. 2810)**

• Complete information on the uses of **Sonneborn's Floorlife Cleaner** for maintenance of wood floors and for cleaning and waxing linoleum is included in an attractive and informative pamphlet issued by the Building Products Div., L. Sonneborn Sons., Inc., 88 Lexington Ave., New York 16. **(Key No. 2812)**

• **"Deming Pumps Everywhere"** is the title of an attractive and informative booklet issued by the Deming Co., Salem, Ohio. The several types of pumps and water systems manufactured by this company and their uses in various fields are described and illustrated. **(Key No. 2813)**

• Hospital administrators and their department heads who are interested in music for therapy, entertainment or any other purpose will want to learn more about the **Thesaurus Library** developed by Radio Corporation of America, RCA Victor Div., Camden, N. J. It is especially designed for use in connection with hospital sound systems and details are available in a bulletin issued by the company. **(Key No. 2846)**

• Details and specifications on **Rockote Sparkproof Plastic Flooring** and its use in hospitals are covered in a folder issued by Federal Flooring Corp., 82 W. Dedham St., Boston 18, Mass. **(Key No. 2821)**

• **Hornlume,** a roof coating which puts asphalt and aluminum on the roof in one operation, thus protecting the surface from ultra violet rays of the sun, is described in an interesting folder issued by A. C. Horn Co., 43-36 Tenth St., Long Island City 1, N. Y. **(Key No. 2822)**

Printed in U.S.A.

Southern Casserole—Ham and yams and fresh green peas smothered in orange juice sweetened with brown sugar. It's delicious, and it looks the part in this Hall China French Casserole.

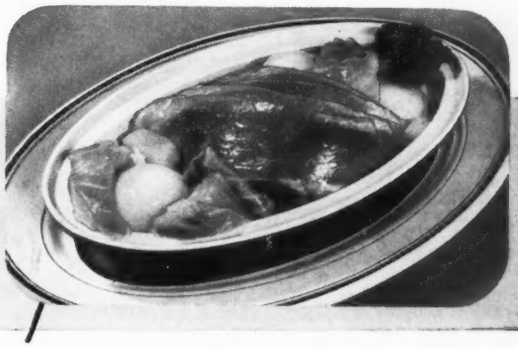
Menu Attractions

INDIVIDUAL RECIPES PREPARED AND SERVED PERFECTLY IN HALL FIREPROOF CHINA

Hall Secret Process China is America's most popular ware in which to prepare and serve casserole menu attractions because . . . First; its thick walls diffuse oven heat so that food is cooked thoroughly and evenly . . . Second; its absorption-proof, fine-textured body retards heat loss and seals in pure, full flavor. Genuine Hall China is made by our secret, single-firing process that fuses body, glaze, and color inseparably. It cannot craze or stain and is known as the hardest china made. It resists chipping because it is exceptionally strong where strength counts . . . in rims, lips and handles. Today . . . with conservation being so vitally necessary . . . it is significant that Hall China has reached a new high in popularity for casserole cuisine.

Above—An unusual salmon recipe with shrimp dressing is perfect in a Hall China Round Casserole.

Below—An old favorite, corned beef and cabbage, reaches a new high in appetizing appeal in this Hall China Oval Casserole.



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HALL

Secret Process

FIREPROOF CHINA

THE HALL CHINA COMPANY · EAST LIVERPOOL, OHIO

World's Largest Manufacturer of Fireproof Cooking China . . . CASSEROLES · BAKING DISHES · COFFEE POTS · TEAPOTS · SERVING ITEMS · ROOM EQUIPMENT ITEMS · STEAM TABLE INSETS · STORAGE VESSELS

LEMON Garden Ornament of Ancient India ...Fruit of a Thousand Uses Today

RAJAHS idling in India's gardens 2,000 years ago admired an ornamental tree bearing globes of wrinkled gold. Centuries later Arabs carried specimens of that pale gold fruit into Spain, gave civilization its first taste of the tonic juice of the Lemon.

Slowly at first, swiftly as knowledge grew, the Lemon's usefulness advanced. First its tartness was used to make beverages thirst-quenching. Then mariners found it a preventive for dreaded scurvy which killed whole crews on long sea voyages, and English law compelled its use on shipboard.

Then oil was squeezed from the peel for flavoring extract, as an essence in perfumes. The peel was grated for confections, candied, employed in medicines. Modern science revealed the Lemon's vitamin richness for health. So the uses expanded to thousands, paced by continuing betterment of fruit and processing.

Thinking perfected the Lemon. Thinking created more abundant, flavorful juice, increased the rind's oil yield, bettered the harvesting, curing, extraction of juice and oil, gave mankind ever-finer Lemon products.

In exactly that way GUMPERT THINKING has perfected *scores* of food products used in your business . . . refined the crude, brought the imperfect product to finer, more flavorful perfection. *Thinking toward perfection* placed and keeps GUMPERT at the forefront of this field—brought us more customers than any food specialty maker ever before served.

GUMPERT KNOWS

How to Use **LEMON** *for Finer* **Gelatine Desserts** *and* **Pie Filling**

THE delicate flavor and richness of GUMPERT Gelatine Dessert and GUMPERT Lemon Pie Filling come from 53 years of "know-how." This full Lemon goodness doesn't cook-out — its Lemon deliciousness "stays put."

Just one of hundreds of GUMPERT Specialties for Restaurants and Institutions.

GUMPERT'S
53rd YEAR

S. GUMPERT CO.
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Manufacturers of Specialty Foods for:

RESTAURANTS • HOTELS • INSTITUTIONS • BAKERIES • ICE CREAM MANUFACTURERS